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# Their Promises of Paradise: Will Olmstead v. L.C. Resuscitate the Constitutional Least Restrictive Alternative Principle in Mental Disability Law

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# ARTICLE

## “THEIR PROMISES OF PARADISE”: WILL *OLMSTEAD V. L.C.* RESUSCITATE THE CONSTITUTIONAL “LEAST RESTRICTIVE ALTERNATIVE” PRINCIPLE IN MENTAL DISABILITY LAW?

*Michael L. Perlin\**

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## I. INTRODUCTION

For nearly three decades, the phrase “least restrictive alternative” (LRA) has been an essential element of mental disability law.<sup>1</sup> From its constitutional roots in a 1972 Wisconsin federal district court decision,<sup>2</sup> through the enactment of state-level “Patient’s Bill of Rights” statutes,<sup>3</sup> and through the articles of nearly every scholar who has written seriously about this question,<sup>4</sup> the concept of the least restrictive alternative—the idea that restrictivity of confinement can and must be calibrated and evaluated—has remained one of the core staples of mental disability law. Initially employed in the mental disability law context in an involuntary civil commitment case (limited to the question of whether an individual need be institutionalized against her will in an in-patient psychiatric hospital),<sup>5</sup> the use of the concept has expanded to consideration of restrictivity of conditions within an institution,<sup>6</sup> adequacy of treatment,<sup>7</sup> (in

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1. See generally 1 MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* §§ 2A-4.4 to -4.4a, at 121-32, §§ 2C-5.3 to -5.3e, at 417-34 (2d ed. 1998) [hereinafter 1 PERLIN, *MENTAL DISABILITY LAW*].

2. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1096-97 (E.D. Wis. 1972) (holding that a state commitment procedure was constitutionally defective because it failed to require those seeking commitment to consider less restrictive alternatives). See generally 1 PERLIN, *MENTAL DISABILITY LAW*, *supra* note 1, § 2A-4.4a, at 126-32, § 2A-4.4c, at 139-42.

3. E.g., N.Y. MENTAL HYG. LAW §§ 33.01-33.21 (McKinney 1996); see generally 2 MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* §§ 3A-14 to -14.5a, at 125-47 (2d ed. 1999) [hereinafter 2 PERLIN, *MENTAL DISABILITY LAW*].

4. See, e.g., 1 PERLIN, *MENTAL DISABILITY LAW*, *supra* note 1, § 2C-5.3, at 417-18 n.828, 419 n.842.

5. *Lessard*, 349 F. Supp. at 1096-97. The use of the LRA in other areas of constitutional law predated *Lessard* by over a decade. Refer to notes 98-110 *infra* and accompanying text.

6. See, e.g., *Goodwin v. Shapiro*, 545 F. Supp. 826, 847-48 (D.N.J. 1982) (indicating

some cases) a patient's right to *refuse* treatment,<sup>8</sup> the right to community aftercare and/or de-institutionalization,<sup>9</sup> and even to cases involving prisoners transferred to mental hospitals<sup>10</sup> and insanity acquittees seeking release.<sup>11</sup>

In the twenty-eight years following *Lessard v. Schmidt*, however, the underpinnings of the doctrine had become somewhat murkier. In 1982, in *Youngberg v. Romeo*,<sup>12</sup> the Supreme Court declined to give the least restrictive alternative constitutional status, articulating instead a constitutionally-minimal standard of "reasonably nonrestrictive confinement conditions."<sup>13</sup> This new language did not cause any states to statutorily revise their involuntary civil commitment standards,<sup>14</sup>

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that mental patients could only be restricted to the extent clinically necessary or necessary to the hospital's internal order and security, but not for administrative convenience).

7. See, e.g., *Gary W. v. Louisiana*, 437 F. Supp. 1209, 1216-19 (E.D. La. 1976) (requiring the hospital staff, when preparing treatment plans for each mentally retarded child, to consider the least restrictive alternative for that child); *Scott v. Plante*, 641 F.2d 117, 129-31 (3d Cir. 1981) (asserting that a mental patient who had been involuntarily confined to the maximum security section of a psychiatric hospital had a right to have his confinement to other less restrictive settings within the hospital carefully considered), *vacated*, 458 U.S. 1101 (1982). For a subsequent case, see *In re James*, 547 N.E.2d 759, 761-62 (Ill. App. Ct. 1989) (illustrating that the absence of a report on appropriateness and availability of alternative treatment facilities and a preliminary treatment plan required commitment reversal).

8. E.g., *Rennie v. Klein*, 653 F.2d 836, 845-47 (3d Cir. 1981) (abandoning the LRA doctrine in drug refusal cases), *vacated*, 458 U.S. 1119 (1982).

9. See, e.g., *Doe v. Knauf*, No. Civ. A. 91-187, 1992 WL 672296, at \*3 (E.D. Ky. Aug. 24, 1992) (holding that plaintiffs have a private right of action to enforce rights of juveniles placed in facilities, including the right to be placed in facilities that are the least restrictive alternative appropriate to the needs of the child and the community).

10. See *Jackson v. Peele*, 22 Crim. L. Rep. (BNA) 2445 (D.D.C. 1978). See also *Johnson v. Levine*, 450 F. Supp. 648, 657-58 (D. Md. 1978) (holding that actively psychotic prisoners and others needing treatment should be transferred from an overcrowded prison to an appropriate state mental institution), *aff'd in part and remanded in part on other grounds*, 588 F.2d 1378 (4th Cir. 1978); *United States ex rel. Souder v. Watson*, 413 F. Supp. 711, 717 (M.D. Pa. 1976) (requiring the same due process guarantees afforded to prisoners for the commitment to mental hospitals as are given to nonprisoners).

11. See *In re Portus*, 371 N.W.2d 871, 872-73 (Mich. Ct. App. 1985) (finding that the trial court should have considered alternatives to hospitalization and whether continued hospitalization was correct for a man who was institutionalized following his acquittal by reason of insanity); *In re Commitment of J.L.J.*, 481 A.2d 563, 565-67, 569-71 (N.J. Super. Ct. App. Div. 1984) (concluding that three former defendants, who were found not guilty by reason of insanity of their respective crimes, and subsequently institutionalized, had a constitutional right to the least restrictive environment appropriate to both the protection of society and the defendants' individual rights).

12. 457 U.S. 307 (1982).

13. *Id.* at 324.

14. See 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-5.3c, at 426 ("The *Youngberg* decision . . . has had little impact on the application of the LRA doctrine to the commitment process.").

but it certainly slowed doctrinal expansion, especially in cases involving the right to refuse treatment.<sup>15</sup> The state of the law became even more muddled a decade later when, in *Riggins v. Nevada*,<sup>16</sup> the Court reinvigorated the doctrine in the context of a case involving the criminal trial of a competent-to-stand-trial insanity defense-pleader, holding that a “least intrusive means” or “least restrictive alternative” methodology must be used in answering the question of whether such a defendant had the right to refuse the involuntary administration of antipsychotic medications at trial.<sup>17</sup>

Notwithstanding this endorsement of the LRA doctrine—albeit in a fact situation far removed from the typical involuntary civil commitment case—doctrinal and theoretical developments continued to stagnate. The LRA was an integral part of involuntary civil commitment law (on the books, at least), but few contemporary judicial opinions spent much time thinking about its contours, its implications, its limitations, or the relationship between *Riggins* and psychiatric hospitalization in civil cases and/or community treatment.<sup>18</sup>

Although the 1990 passage of the Americans with Disabilities Act<sup>19</sup> could have logically and reasonably been seen as auguring a reversal of this trend,<sup>20</sup> few developments in the subsequent nine years suggested that such a reversal was likely. Notwithstanding explicit regulatory language mandating that a “public entity shall administer services, programs, and activities in the *most integrated setting* appropriate to the needs of qualified individuals with disabilities,”<sup>21</sup> few ADA cases ever spoke to LRA concerns.<sup>22</sup>

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15. See *Rennie v. Klein*, 720 F.2d 266, 269–70 (3d Cir. 1983) (rejecting a “least intrusive means” standard for administering antipsychotic drugs to involuntarily committed mental patients and utilizing professional judgment to make medication determinations); 2 PERLIN, MENTAL DISABILITY LAW, *supra* note 3, § 3B-5.10, at 246 (discussing this aspect of the *Rennie* remand opinion).

16. 504 U.S. 127 (1992).

17. *Id.* at 129–30, 135–36. See also 2 PERLIN, MENTAL DISABILITY LAW, *supra* note 3, § 3B-8.3, at 327 (discussing this aspect of *Riggins*).

18. See, e.g., *Jurasek v. Utah State Hosp.*, 158 F.3d 506, 511 (10th Cir. 1998) (citing *Riggins* and stating that “[o]ur reasoning is further supported by the Supreme Court’s application of the principles enunciated in [*Washington v. Harper*], 494 U.S. 210 (1990)] to a pretrial detainee who had been found incompetent to stand trial, but had not been civilly committed”).

19. 42 U.S.C. §§ 12101–12213 (1994 & Supp. IV 1998).

20. See, e.g., Guido S. Weber, *Unresolved Issues in Controlling the Tuberculosis Epidemic Among the Foreign-Born in the United States*, 22 AM. J.L. & MED. 503, 535 (1996) (“ADA standards are synonymous with due process standards already in place, such as an individualized assessment and using the least restrictive alternatives.”).

21. 28 C.F.R. § 35.130(d) (1999) (emphasis added). See also 42 U.S.C. § 12182(b)(1)(B) (1994) (“Goods, services, facilities, privileges, advantages, and

The 1999 Supreme Court decision in *Olmstead v. L.C.*,<sup>23</sup> however, may serve to reverse this trend of inaction and may resuscitate and revitalize the constitutionally-grounded LRA principle in mental disability law. *Olmstead* qualifiedly affirmed an Eleventh Circuit decision that had ruled that the ADA entitled plaintiffs—residents of Georgia Regional Hospital—to treatment in an integrated community setting as opposed to an “unnecessarily segregated” state hospital.<sup>24</sup> In writing the majority opinion, Justice Ginsburg stressed that “[u]njustified isolation . . . is properly regarded as discrimination based on disability,”<sup>25</sup> and ordered that states be required to maintain “a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings.”<sup>26</sup> This explicit endorsement of the ADA’s “integration mandate”<sup>27</sup> forces us to reconsider the role of the least restrictive alternative in mental disability law, how courts assess such cases, and the range of evidence admissible at involuntary civil commitment hearings. *Olmstead* also, by specifically incorporating “least restrictive alternative” language—albeit in a case that it specifically denominated as statutory and *not* constitutional<sup>28</sup>—forces each state to reconceptualize both the involuntary civil commitment hearing and the periodic review process.<sup>29</sup>

This Article proceeds in the following manner. First, I provide an historical perspective with a brief overview of the pattern and practices of institutional segregation that have been

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accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.”).

22. One of the few exceptions is *City of Newark v. J.S.*, 652 A.2d 265, 274–78 (N.J. Super. Ct. Law Div. 1993) (holding that a statute authorizing the involuntary commitment of a homeless person suffering from tuberculosis was not invalid, but that the statute would have to be construed to include rights required by the Americans with Disabilities Act, and rights required by contemporary standards of due process, including the least restrictive mode of isolation). See also Michael L. Perlin, “*Make Promises by the Hour*”: Sex, Drugs, the ADA, and Psychiatric Hospitalization, 46 DEPAUL L. REV. 947, 974–75 (1997) [hereinafter Perlin, *Promises by the Hour*] (discussing *City of Newark v. J.S.*).

23. 527 U.S. 581 (1999).

24. *L.C. v. Olmstead*, 138 F.3d 893, 895, 897 (11th Cir. 1998), *aff’d in part, vacated in part* by 527 U.S. 581 (1999).

25. *Olmstead*, 527 U.S. at 597.

26. *Id.* at 605–06.

27. 28 C.F.R. pt. 35 app. A (1998).

28. *Olmstead*, 527 U.S. at 588.

29. Refer to Part III.B *infra*. See generally PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL § 6.44AA, at 83–94 (Supp. 1999) [hereinafter PERLIN, MENTAL DISABILITY LAW (Cum. Supp. 1999)]; Michael L. Perlin, “*I Ain’t Gonna Work on Maggie’s Farm No More*”: Institutional Segregation, Community Treatment, the ADA, and the Promise of *Olmstead v. L.C.*, 17 T.M. COOLEY L. REV. 53 (2000) [hereinafter Perlin, *Maggie’s Farm*].

the hallmark of American in-patient psychiatry, then a review of the development of the least restrictive alternative doctrine (beginning with the trail-blazing decision in *Lessard*, post-*Lessard* constitutional developments, and statutory reform), a consideration of the functional role of the involuntary civil commitment and periodic review hearing, and a (regretful) post-mortem—in the wake of *Pennhurst State School v. Halderman*—for constitutionally-based “right to community treatment” litigation.

Next, I look briefly at the ADA, and then tackle the heart of the paper—the impact of the ADA and *Olmstead* on institutional segregation and the potential rebirth of a constitutionally-based least restrictive alternative after *Olmstead* (keeping in mind that *Olmstead* was *not* a constitutional case). I believe that, after *Olmstead*, involuntary civil commitment/periodic review hearings must be expanded to consider—as an element of the commitment process—an inquiry into the restrictivity of confinement, and, at such hearings, evidence of the impact of institutional segregation and the availability of community treatment alternatives should be admissible (a change of focus that will force counsel to assume an expanded role at such hearings). Courts will also be forced to reconceptualize the meaning of “restrictivity of confinement” at such hearings, a reconceptualization that parallels suggestions that right to refuse treatment law be guided by a calibration of a “continuum of coerciveness.” *Olmstead* may also revive interest in constitutionally-based community treatment litigation, and may force us to reconsider the trend—exemplified by New York’s passage of “Kendra’s Law”—of expanded outpatient commitment initiatives.

I then explore several themes that have been at the core of my recent work—the meanings of “sanism” and “pretextuality,” and the role of “therapeutic jurisprudence.” Here, I conclude that *Olmstead* has tremendous (albeit still-untapped) potential for combating both sanism and pretextuality in the involuntary civil commitment/periodic review process, and that its expanded role/use—as a tool to enforce the least restrictive alternative mandate—is clearly therapeutic. I will conclude with some recommendations and some thoughts as to how this may potentially influence other aspects of institutional mental disability law.

My title comes from *Gates of Eden*, Bob Dylan’s brilliant and transcendental<sup>30</sup> vision of an earthly paradise, a “quest for

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30. CRAIG MCGREGOR, *Introduction* to BOB DYLAN: A RETROSPECTIVE 1, 2 (Craig McGregor ed., 1972).

salvation”<sup>31</sup> or, an “epic-length extrapolation[] on the human condition.”<sup>32</sup> Writes Dylan:

With a time-rusted compass blade

Aladdin and his lamp

Sits with Utopian hermit monks

Side saddle on the Golden Calf

And on their promises of paradise

You will not hear a laugh

All except inside the Gates of Eden.<sup>33</sup>

Whether the song is borrowed from Blake (as Robert Shelton suggests),<sup>34</sup> or whether it is a song “that breaks bonds,” that “burst[s] forth . . . into freedom,”<sup>35</sup> *Eden* is Dylan’s demonstration that “[t]he present world is one of illusion.”<sup>36</sup> To all too many persons with mental disabilities, the LRA concept has forever been little more than an “illusion.” The *Olmstead* case, by resuscitating the LRA doctrine, may prove to be a vehicle for “salvation” for those inappropriately institutionalized. It “promises . . . paradise.” Whether that promise will be delivered is still far from clear.

## II. AN HISTORICAL PERSPECTIVE

### A. *The Roots of Institutional Segregation*<sup>37</sup>

The history of psychiatric institutions in the United States has been one of institutional segregation. An early history of a Pennsylvania facility, for example, decried the lack of legal protections made available to institutionalized patients:

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31. ROBERT SHELTON, *NO DIRECTION HOME: THE LIFE AND MUSIC OF BOB DYLAN* 275 (Da Capo Press 1997) (1986).

32. BOB SPITZ, *DYLAN: A BIOGRAPHY* 271 (1989).

33. BOB DYLAN, *LYRICS, 1962–1985*, at 174 (1995). I cannot resist one burst of self-referentiality. I saw Dylan perform the world premiere of *Gates* in New York City in October 1964.

34. SHELTON, *supra* note 31, at 276.

35. *Adventures in Chaos: Bob Dylan as Poet*, at <http://www.jps.net/salvo/dylan.htm> (last modified Feb. 24, 1997).

36. Bert Cartwright, *Talkin’ Devil with Bob Dylan*, at <http://users.powernet.co.uk/barrett/The-Telegraph/extracts/devil49.html> (last visited Sept. 30, 2000).

37. This section is adapted from 1 PERLIN, *MENTAL DISABILITY LAW*, *supra* note 1, § 2A-2.1b to -2.1c. See also *id.* § 2A-2.1a (discussing the “European roots” of civil commitment).



In the earlier days of the Hospital, even down to quite recent times, the mode of commitment of the insane was so easy and free from formality that a few words hastily scribbled upon a chance scrap of paper were sufficient to place a supposed insane person in the Hospital and deprive him of personal liberty. . . . A sufficient number of such scraps of paper have survived to show the astonishing informality of the lunacy proceedings. The friend (or it may in some instances have been the enemy) of an alleged lunatic, applied to the Managers, or to one of the physicians, for an order of admission. . . . If the patient was indigent he was admitted as a free case, after being seen by one of the physicians and upon his report to the Managers that the patient was a fit subject for detention. Once in his cells, or quarters for the insane, the patient had no appeal from the opinion of the attending physician.<sup>38</sup>

A 1788 New York law, noting that "there are sometimes persons, who by lunacy or otherwise are furiously mad, or are so far disordered in their senses that they may be dangerous to be permitted to go abroad," authorized two or more justices to direct constables to "cause such person to be apprehended and kept safely locked up in some secure place[,] . . . and (if such justices shall find it necessary) to be there chained."<sup>39</sup>

At this time, it was considered critical that the "insane" person be isolated as rapidly and effectively as possible from the sources of his illness in the outside world.<sup>40</sup> Commitment matters were viewed strictly as administrative procedures,<sup>41</sup> and the application of the local overseer of the poor was often seen as a sufficient basis on which to place an "indigent insane" in a public institution.<sup>42</sup> Thus:

[M]edical superintendents were also eager to leave commitment laws as simple and as uncomplicated as

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38. THOMAS G. MORTON, *THE HISTORY OF THE PENNSYLVANIA HOSPITAL, 1751-1895* (rev. ed. 1897), reprinted in Thomas G. Morton, *The Pennsylvania Hospital: Its Founding and Functions*, in *THE AGE OF MADNESS: THE HISTORY OF INVOLUNTARY MENTAL HOSPITALIZATION PRESENTED IN SELECTED TEXTS 13-14* (Thomas S. Szasz ed., 1973).

39. 1788 N.Y. LAWS, ch. 31.

40. DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC 143* (1971).

41. NICHOLAS N. KITTRIE, *THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY 64* (1971).

42. *Id.*; ALBERT DEUTSCH, *THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES 420-21* (2d ed., Columbia Univ. Press 1949) (1937). Thus, under Illinois law, a married woman who, in the judgment of the institution's superintendent was evidently "insane or distracted, may be entered or detained at the request of the husband . . . , *without the evidence in other cases.*" 1851 Ill. Laws § 10, at 96, 98 (emphasis added).

possible. Most superintendents preferred to allow relatives to bring the patient directly to the institution and arrange for commitment on the spot; only a few believed that prior judicial examination or jury decisions were necessary. The managers of the Utica asylum, for example, objected strenuously to legal formalities in its incorporation act that made the certification of insanity under oath by two "respectable physicians," a prerequisite for admission.<sup>43</sup>

The first commitment "procedures" reflected the attitudes of the hospital superintendents described by Rothman. According to Professor Deutsch, commitment could be effected with "the greatest of ease," and there were no specific legislative safeguards to protect the personal liberty of the supposedly mentally ill person until at least the second quarter of the nineteenth century.<sup>44</sup>

As institutions proliferated—in Rothman's words, a "cult of asylum swept the country"<sup>45</sup>—"therapeutic concerns were slowly being pushed into the background"<sup>46</sup> in a system in which the "presence of larger hospitals tended 'to accelerate the thrust toward greater reliance on institutional care of the mentally ill, which in turn increased the demand for more facilities[,] . . . result[ing in] a constant cycle of growth that resulted in larger and larger institutions.'" According to Professor Grob: "Faith in administrative rationality was so pervasive that systematizers often concluded that efficiency and policy were one and the same. They assumed that efficient administration would *ipso facto* create humane and effective public policies . . . ."<sup>48</sup>

While several early state institutions for mentally ill persons were led by enlightened superintendents<sup>49</sup> who—following the

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43. ROTHMAN, *supra* note 40, at 143; N.Y. Lunatic Asylum, *Annual Report*, 1 N.Y. SEN. DOC. NOS. 20, 63, 81–82, 93, 123, 149 (1842); N.Y. Lunatic Asylum, *Annual Report*, 3 N.Y. ASSEMBLY DOC. NOS. 50, 56–59 (1843).

44. DEUTSCH, *supra* note 42, at 420.

45. ROTHMAN, *supra* note 40, at 130.

46. GERALD N. GROB, *MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875*, at 205 (1973) [hereinafter GROB, *MENTAL INSTITUTIONS*]. See also GERALD N. GROB, *MENTAL ILLNESS AND AMERICAN SOCIETY, 1875–1940*, at 210–24 (1983) [hereinafter GROB, *MENTAL ILLNESS*] (discussing how the formation of "boards" to operate mental institutions led to an extensive bureaucracy that largely ignored the interests of mental patients).

47. James R. Elkins, *Legal Representation of the Mentally Ill*, 82 W. VA. L. REV. 157, 169 (1979) (quoting GROB, *MENTAL INSTITUTIONS*, *supra* note 46, at 191). For an excellent and helpful overview, see S. A. Shah, *Therapeutic Sanctions and Fundamental Notions of Justice: A Basic Dilemma in Law and Mental Health Interactions*, in HARMONIE EN TEGENSpraak 317 (C. Kelk et al. eds., 1990).

48. GROB, *MENTAL ILLNESS*, *supra* note 46, at 203.

49. See John E. B. Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367, 371–72 (1983–84) (discussing early

seminal work of William Tuke and others<sup>50</sup>—founded the “moral treatment” movement,<sup>51</sup> “the great majority of mentally ill persons who were public dependents remained unaffected by the great psychiatric reforms of the time.”<sup>52</sup> According to Professor Myers, “the forms of institutional neglect so poignantly described by Dickens became the rule rather than the exception.”<sup>53</sup> In light of the increase in the *number* of institutions,<sup>54</sup> “the serious consequences of the total lack of legislation defining commitment procedures became more and more manifest.”<sup>55</sup>

Subsequently, the criteria for involuntary civil commitment were established in state-by-state enactments that “constitut[e] the basic legislative pattern . . . in force [until the 1950’s],”<sup>56</sup> and remained “fairly static.”<sup>57</sup> As late as 1960, the Iowa Supreme Court held that involuntary civil commitment was not such a loss

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superintendents at mental institutions who followed the moral treatment movement, treating patients “in as normal and pleasant an environment as possible”).

50. See generally George Mora, *Historical and Theoretical Trends in Psychiatry*, in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY-II 1, 42–44 (Alfred M. Freedman et al. eds., 2d ed. 1975). For a blistering social attack on Tuke, Pinel, and other “social reformers,” see MICHEL FOUCAULT, *MADNESS AND CIVILIZATION: A HISTORY OF INSANITY IN THE AGE OF REASON* 241–78 (Richard Howard trans., Vintage Books 1973) (1961).

51. According to Dr. John Talbott, the moral treatment movement called for “humane treatment, kindness, open wards, pleasant surroundings, no or minimal restraints, structured activity, and, above all, a familiar, if not parental relationship between superintendent and patients, which included joint dining, walks in the countryside, etc.” JOHN A. TALBOTT, *THE DEATH OF THE ASYLUM* 16 (1978) (citing, *inter alia*, Norman Dain, *From Colonial America to Bicentennial America: Two Centuries of Vicissitudes in the Institutional Care of Mental Patients*, 52 BULL. N.Y. ACAD. MED. 1179 (1976)).

52. DEUTSCH, *supra* note 42, at 116.

53. Myers, *supra* note 49, at 373 (alluding to Charles Dickens’s description of the Pennsylvania Eastern Penitentiary in AMERICAN NOTES AND REPRINTED PIECES ch. VII (London, Virtue and Co., Ltd.) (1842)).

54. For an economically deterministic point of view, see ANDREW I. SCULL, *DECARCERATION: COMMUNITY TREATMENT AND THE DEVIANT: A RADICAL VIEW* 24 (2d ed., Rutgers Univ. Press 1984) (1977) (“I would contend that many of the transformations underlying the move toward institutionalization can be more plausibly tied to the growth of the capitalist market system and to its impact on economic and social relationships.”).

55. DEUTSCH, *supra* note 42, at 422.

56. Myers, *supra* note 49, at 377 n.49 (quoting SAMUEL J. BRAKEL & RONALD S. ROCK, *THE MENTALLY DISABLED AND THE LAW* 8 (rev. ed. 1971)).

57. Myers, *supra* note 49, at 377. See 1 THE INSTITUTIONAL CARE OF THE INSANE 335–37 (Henry M. Hurd ed., Arno Press 1973) (1916–17) (describing commitment statutes as of 1916); *id.* at 338–43 (describing rules governing institutional discharge). Then-current cases are summarized in 1 S.V. CLEVINGER, *MEDICAL JURISPRUDENCE OF INSANITY OR FORENSIC PSYCHIATRY* 443–45 (1898). See also Ellen Dwyer, *Civil Commitment Laws in Nineteenth-Century New York*, 6 BEHAV. SCI. & L. 79, 82, 96 (1988) (evaluating the social role of civil commitment laws in one nineteenth century jurisdiction and revealing that both families and communities used mental institutions as “long-term holding places” for the “socially marginal and threatening”).

of liberty as to fall within the protection of the due process clause of the Fourteenth Amendment.<sup>58</sup>

As of 1961, of the thirty-seven jurisdictions that provided for some sort of judicial procedures to govern involuntary hospitalization, only five couched the operative test for committability solely in terms of dangerousness,<sup>59</sup> and seven provided no other basis for hospitalization beyond the patient's need for care and treatment.<sup>60</sup> In recognition that the language of civil commitment statutes was "almost universally obscure,"<sup>61</sup> the commentary to the first major model civil commitment legislation, the National Institute of Mental Health's *Draft Act Governing Hospitalization of the Mentally Ill*,<sup>62</sup> listed two

58. *Prochaska v. Brinegar*, 102 N.W.2d 870, 872 (Iowa 1960). The court stated:

It must be kept in mind that Appellant is not charged with a crime and is not so incarcerated. He is being restrained of his liberty in that he is not free to come and go at will but such restraint is not in the way of punishment, but for his own protection and welfare as well as for the benefit of society. Such loss of liberty is not such liberty as is within the meaning of the constitutional provision that "no person shall be deprived of life, liberty or property without due process of law."

*Id.*

59. *THE MENTALLY DISABLED AND THE LAW* 17 (Frank T. Lindman & Donald M. McIntyre, Jr. eds., 1961) [hereinafter *MENTALLY DISABLED AND THE LAW*]. See also *id.* at 44-51 (listing the statutory definitions of "mentally ill" in the thirty-seven jurisdictions).

60. *Id.* at 17. As recently as 1974, fifteen states allowed for compulsory hospitalization based on a finding of a mental illness that rendered the individual in need of care and treatment, a fit subject for hospitalization. *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1203-04 (1974) [hereinafter *Developments*]. See also *id.* at 1204 n.14 (listing pertinent statutes). See, e.g., ALA. CODE tit. 45, § 210 (1959 & Supp. 1973) (applying a standard of "sufficiently defective mentally" to be committed). But see *Lynch v. Baxley*, 386 F. Supp. 378, 387 (M.D. Ala. 1974) (declaring the Alabama statute unconstitutional), *superseded by statute as stated in Garrett v. State*, 707 So.2d 273, 274-75 (Ala. Civ. App. 1997).

61. *MENTALLY DISABLED AND THE LAW*, *supra* note 59, at 20. See also Hugh Alan Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, 965 (1959) (declaring that commitment statutes are often "loosely worded," reflecting a "bewildering array of commitment methods").

62. NAT'L INST. OF MENTAL HEALTH, *A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL* (Public Health Service Pub. No. 51, 1952) [hereinafter *DRAFT ACT*], reprinted in *MENTALLY DISABLED AND THE LAW*, *supra* note 59, at 397 app. A. The Draft Act was seen as enormously influential. See, e.g., James E. Beaver, *The "Mentally Ill" and the Law: Sisyphus and Zeus*, 1968 UTAH L. REV. 1, 4 (1968); William J. Curran, *Hospitalization of the Mentally Ill*, 31 N.C. L. REV. 274, 278 (1953) (noting that the Draft Act specifically recognized that many mental patients do not have the capacity to make an application for commitment); Sanford H. Kadish, *A Case Study in the Signification of Procedural Due Process—Institutionalizing the Mentally Ill*, 9 W. POL. Q. 93, 97-98 (1956) (stating that the Draft Act "represents a careful and painstaking examination of the problems under discussion"); Gary D. Taylor, *A Critical Look into the Involuntary Civil Commitment Procedure*, 10 WASHBURN L.J. 237, 239 (1971) (explaining that the Draft Act provided an alternative ground for the compulsory commitment of the mentally ill to those accepted at the time). Subsequently, the Draft Act was proposed as a uniform law model for the states to adopt. Note, *Comments of a Draft Act for the Hospitalization of the*

alternative grounds on which the involuntary hospitalization of a mentally ill individual might be ordered: (1) the likelihood that the individual will injure himself or others if he is not confined, and (2) need of hospitalization and lack of sufficient insight or capacity to make responsible decisions with respect to the question of hospitalization.<sup>63</sup>

The Draft Act, which envisioned a system in which "indeterminate involuntary hospitalization" would be "under judicial control from the beginning,"<sup>64</sup> provided for notice,<sup>65</sup> a full hearing,<sup>66</sup> continuing review of the propriety of detention,<sup>67</sup> and access on the part of institutionalized persons to the court to effect discharges.<sup>68</sup> This act became the impetus for a significant number of revisions to commitment statutes in the late 1950s and 1960s,<sup>69</sup> reflecting "a trend toward restricting involuntary civil commitment to the dangerous mentally ill and toward limiting the type and increasing the severity of harm necessary to support a finding of dangerousness."<sup>70</sup>

### *B. Development of the Least Restrictive Alternative Doctrine<sup>71</sup>*

Perhaps no other principle has permeated the full body of mental disability law and litigation as has the doctrine of the least restrictive alternative. Although never specifically endorsed by the U.S. Supreme Court before 1999 in a civil case involving persons with mental disabilities,<sup>72</sup> it has been invoked in

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*Mentally Ill*, 19 GEO. WASH. L. REV. 512, 512-13 (1951) (discussing those groups that helped prepare the Draft Act and the purpose of promulgating it to the various states). See, e.g., *State ex rel. Fuller v. Mullinax*, 269 S.W.2d 72, 73 (Mo. 1954) (noting that elements of the Draft Act were taken from the statutes of various states).

63. DRAFT ACT, *supra* note 62, at 411. These grounds themselves were not universally seen as models of clarity. See *MENTALLY DISABLED AND THE LAW*, *supra* note 59, at 20 ("Even the Draft Act, which is considered as precise as any of the statutes, is subject to a variety of interpretations.").

64. DRAFT ACT, *supra* note 62, at 397-98.

65. *Id.* § 9(b), at 401-02.

66. *Id.* § 9(f), at 402.

67. *Id.* § 18, at 404.

68. *Id.* §§ 17(a), 18, at 404.

69. See EDWARD B. BEIS, *MENTAL HEALTH AND THE LAW* 6 (1984). For a survey of statutes compiled soon after the first wave of constitutional litigation in this area, see *id.* at 297-321.

70. *Developments*, *supra* note 60, at 1205. This was a policy change to which the legal commentators gave "nearly unanimous" support. Myers, *supra* note 49, at 379.

71. This section is largely adapted from 1 PERLIN, *MENTAL DISABILITY LAW*, *supra* note 1, § 2C-5.3.

72. See generally 2 PERLIN, *MENTAL DISABILITY LAW*, *supra* note 3, § 3A-9.5 (discussing the Supreme Court's use of the phrase "reasonably non-restrictive confinement conditions" in *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982)). On the re-emergence of the "least intrusive means" test in *Riggins v. Nevada*, 504 U.S. 127, 135

virtually every major challenge to the limitations of the substantive involuntary civil commitment power,<sup>73</sup> as well as in nearly every significant test case seeking a judicial declaration of a right to treatment,<sup>74</sup> a right to refuse treatment,<sup>75</sup> or a right to aftercare and/or de-institutionalization.<sup>76</sup> Moreover, this principle has been incorporated in many civil commitment statutes,<sup>77</sup> and is routinely invoked at individual commitment hearings on a daily basis.<sup>78</sup> The importance of this doctrine to the fabric of the commitment process cannot be overstated.

The LRA doctrine has its basis in the Supreme Court doctrine that requires the government "to pursue its ends by means narrowly tailored so as not to encroach unnecessarily on important competing interests."<sup>79</sup> While the legal roots<sup>80</sup> of the LRA doctrine can be found in the early nineteenth century,<sup>81</sup> the classic statement comes from *Shelton v. Tucker*,<sup>82</sup> a 1960 case invalidating an Arkansas law that had required all state-employed teachers to file affidavits listing all organizations to which they belonged or to which they made financial contributions:<sup>83</sup>

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(1992), see 2 PERLIN, MENTAL DISABILITY LAW, *supra* note 3, § 3B-8.3. To be sure, the Court's endorsement of the doctrine in *Olmstead* was not in the context of an involuntary civil commitment case. Refer to Part III.B *infra*.

73. See 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-5.3b.

74. See 2 PERLIN, MENTAL DISABILITY LAW, *supra* note 3, § 3A-3.1.

75. See *id.* § 3B-5.5b.

76. See 2 MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL ch. 7 (1989) [hereinafter 2 PERLIN, MENTAL DISABILITY LAW (1st ed.)].

77. This, of course, is a relatively recent development. Compare Ingo Keilitz et al., *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice*, 29 ST. LOUIS U. L.J. 691, 709-10 n.101 (1985) (listing statutes in thirty-nine states that, as of 1985, required courts to consider alternatives to hospitalization at time of involuntary civil commitment proceeding), with David L. Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1108, 1139-40 n.140 (1972) [hereinafter Chambers, *Alternatives*] (listing statutes in the only nine states that required a similar consideration of alternatives in 1972).

78. See 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, §§ 2C-5.3b to -5.3c.

79. David Zlotnick, *First Do No Harm: Least Restrictive Alternative Analysis and the Right of Mental Patients to Refuse Treatment*, 83 W. VA. L. REV. 375, 381 (1981) (citing *Shelton v. Tucker*, 364 U.S. 479, 488 (1960)).

80. Commentators have traced the doctrine's philosophical roots to the fourteenth century principle of "Ockham's Razor." Keilitz et al., *supra* note 77, at 696-97.

81. Zlotnick traces the LRA doctrine's first appearance in American jurisprudence to *Anderson v. Dunn*, 19 U.S. (6 Wheat.) 204, 230-31 (1821). Zlotnick, *supra* note 79, at 385.

82. 364 U.S. 479 (1960).

83. *Id.* at 480, 490. Prior to *Shelton*, this phrase was employed more frequently in commerce clause cases involving economic regulation. See, e.g., *Dean Milk Co. v. City of Madison*, 340 U.S. 349, 354 (1951) (holding that a state does not have unlimited power to "protect the health and safety of its people, if reasonable nondiscriminatory alternatives, adequate to conserve legitimate local interests, are available"). See generally Richard B.

In a series of decisions this Court has held that, even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.<sup>84</sup>

Subsequently, the Court has used a similar means of analysis in cases involving such basic rights as freedom of association,<sup>85</sup> freedom to travel,<sup>86</sup> freedom to practice one's religion,<sup>87</sup> freedom to exercise the voting franchise,<sup>88</sup> and privacy between marriage partners.<sup>89</sup> This doctrine has been interpreted to require courts to "ensure that the state imposes no greater constriction of freedom than necessary to serve [its] objectives"<sup>90</sup> in cases involving an attempt to regulate "constitutionally preferred activities or constitutionally protected groups."<sup>91</sup>

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Saphire, *The Civilly-Committed Public Mental Patient and the Right to Aftercare*, 4 FLA. ST. U. L. REV. 232, 274-78 (1976) (discussing the origins of the least restrictive alternative doctrine in constitutional law).

84. *Shelton*, 364 U.S. at 488 (footnote omitted).

85. *United States v. Robel*, 389 U.S. 258, 259-60, 265-66 (1967) (rejecting as overbroad a statute that barred members of certain communist organizations from employment at a defense facility because it impinged on the First Amendment rights of free association).

86. *See, e.g., Shapiro v. Thompson*, 394 U.S. 618, 633 (1969) (holding that a state's valid interest in preserving the fiscal integrity of its programs cannot be accomplished through "invidious distinctions" between classes of its citizens); *Aptheker v. Sec'y of State*, 378 U.S. 500, 501-02, 505 (1964) (finding that a statute denying passports to certain members of the Communist Party "too broadly and indiscriminately" restricted the right to travel).

87. *See, e.g., Sherbert v. Verner*, 374 U.S. 398, 406-07 (1963) (finding no valid justification for the state to deny the appellant's right to receive unemployment benefits due to her religious beliefs).

88. *See, e.g., Dunn v. Blumstein*, 405 U.S. 330, 334, 343 (1972) (declaring that a state must choose "less drastic means" if there are other reasonable methods of achieving its goals—especially when the proposed statute affects constitutional rights); *Carrington v. Rash*, 380 U.S. 89, 96 (1965) (explaining that the Constitution does not permit discrimination based on voters' occupations).

89. *See, e.g., Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965) (stating that laws affecting the privacy of the marital bedroom must be narrowly drawn).

90. Chambers, *Alternatives*, *supra* note 77, at 1111.

91. David Chambers, *Right to the Least Restrictive Alternative Setting for Treatment*, in 2 LEGAL RIGHTS OF THE MENTALLY HANDICAPPED 991, 997 (Bruce J. Ennis & Paul R. Friedman eds., 1973). The Supreme Court returned to this mode of analysis earlier this year in determining that a cable television law, requiring cable operators either to scramble sexually explicit channels in full or limit programming on such channels to certain hours, was unconstitutional, in that the government failed to show that this law was the least restrictive means of achieving the government's goal of preventing children from hearing or seeing certain sexually explicit images. *United States v. Playboy Entm't Group*, 120 S. Ct. 1878, 1882-83, 1888 (2000).

It was thus "inevitable" that the LRA doctrine would be applied to the involuntary civil commitment process,<sup>92</sup> with its attendant "massive curtailment of liberty,"<sup>93</sup> that it would be seen as a possible means of reconciliation between "civil libertarians concerned about unwarranted intrusions upon individual liberties and clinicians concerned more with successful treatment than with temporary restrictions on personal freedom,"<sup>94</sup> and that it would become "a cornerstone in the developing body of law dealing with the rights of mentally handicapped persons."<sup>95</sup>

### C. Constitutional Underpinnings<sup>96</sup>

The LRA doctrine was given constitutional life<sup>97</sup> in the mental health context for the first time in *Lessard v. Schmidt*.<sup>98</sup> There, the federal district court ruled that: "Even if the standards for an adjudication of mental illness and potential dangerousness are satisfied, a court should order full-time involuntary hospitalization only as a last resort."<sup>99</sup> Quoting *Shelton v. Tucker*,<sup>100</sup> the court characterized "the most basic and fundamental right" as "the right to be free from unwanted restraint,"<sup>101</sup> concluding that "persons suffering from the condition of being mentally ill, but who are not alleged to have committed any crime, cannot be totally deprived of their liberty if there are less drastic means for achieving the same basic goal."<sup>102</sup> Endorsing *Lake v. Cameron*,<sup>103</sup> the court placed the burden for exploring alternatives to institutionalization on "the person recommending full-time involuntary hospitalization,"<sup>104</sup> who must prove the following:

92. Zlotnick, *supra* note 79, at 382.

93. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

94. P. Browning Hoffman & Lawrence L. Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of its Senses*, 14 SAN DIEGO L. REV. 1100, 1102-03 (1977).

95. Zlotnick, *supra* note 79, at 382.

96. This section is adapted from 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-5.3a. See also Michael L. Perlin, "For the Misdemeanor Outlaw": *The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA. L. REV. (forthcoming 2000) [hereinafter Perlin, *Misdemeanor Outlaw*].

97. On the first statutory LRA cases, see 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-5.3a, at 419 (discussing *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966)).

98. 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473 (1974).

99. *Id.* at 1095.

100. 364 U.S. 479, 488 (1960).

101. *Lessard*, 349 F. Supp. at 1095-96.

102. *Id.* at 1096.

103. 364 F.2d 657, 660 (D.C. Cir. 1966) (stating that the state must bear the burden of exploring alternatives).

104. *Lessard*, 349 F. Supp. at 1096. But see Elkins, *supra* note 47, at 225 (observing



(1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable. These alternatives include voluntary or court-ordered out-patient treatment, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or relative, placement in a nursing home, referral to a community mental health clinic, and home health aide services.<sup>105</sup>

In analyzing the LRA in this context, Ingo Keilitz and his colleagues listed factors to be considered in making such a determination:

[T]he environmental restrictiveness of the treatment setting; the psychological or physical restrictiveness of behavioral, chemical, or biological treatments; clinical variables, including the person's behavior as it relates to the legal criteria for involuntary commitment; the relative risks and benefits of treatment alternatives; the family and community support available in the person's environment; the quality or likely effectiveness of the alternative care and treatment; the duration of treatment; the likelihood that a person may pose a risk to public safety; the availability, cost, and accessibility of alternative treatment and care; the likelihood of the person's cooperation or compliance with the conditions of alternative treatment programs; and mechanisms for monitoring and reviewing that compliance.<sup>106</sup>

*Lessard's* reasoning was subsequently adopted in other civil commitment challenges,<sup>107</sup> and was endorsed extensively in the

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that the investigative function as to alternatives "may, as a result of inaction or inattention by the mental health professionals, fall to defense counsel").

105. *Lessard*, 349 F. Supp. at 1096.

106. Keilitz et al., *supra* note 77, at 696.

107. See, e.g., *Lynch v. Baxley*, 386 F. Supp. 378, 392 (M.D. Ala. 1974) (declaring that "the state, which knows or has the means of knowing the available alternatives, must bear the burden of proving what alternatives are available"), *superseded by statute as stated in* *Garrett v. State*, 707 So.2d 273, 274-75 (Ala. Civ. App. 1997); *Suzuki v. Quisenberry*, 411 F. Supp. 1113, 1132-33 (D. Haw. 1976) (reiterating the requirement that less drastic means than commitment be investigated by the state); *In re D.D.*, 285 A.2d 283, 286 (N.J. Super. Ct. App. Div. 1971) (stating that "civil confinement for an indefinite duration may be sufficiently inhumane so as to constitute cruel and unusual punishment"); *Kesselbrenner v. Anonymous*, 305 N.E.2d 903, 905 (N.Y. 1973) (declaring that "subject[ing] a person to a greater deprivation of personal liberty than necessary . . . [is] violative of due process").

While the continued vitality of the LRA doctrine has been questioned in treatment matters, see *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982); see generally 2 Perlin, *Mental Disability Law*, *supra* note 3, §§ 3A-9.5 to -9.7, its application to the commitment process is consistent:

[T]he principle of the least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil commitment, which

literature.<sup>108</sup> Again, Keilitz and his colleagues offered this clinical/legal definition:

[The LRA] in involuntary civil commitment proceedings is the combination of therapeutic and preventative intervention provided by mental health and social service providers that a) is conducive to the most effective and appropriate treatment that will give the mentally disordered person a realistic opportunity to improve his or her level of functioning, and b) is no more restrictive of a person's physical, social, or biological liberties than is necessary to achieve legitimate state purposes of protecting society and providing mental health treatment and care for the individual.<sup>109</sup>

Other courts quickly expanded the scope of the LRA doctrine beyond involuntary civil commitment decision making<sup>110</sup> to include regulation of the conditions of confinement,<sup>111</sup> the availability of treatment,<sup>112</sup> the right of a patient to refuse

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entails an extraordinary deprivation of liberty justifiable only when the respondent is "mentally ill to the extent that he is likely to injure himself or other persons if allowed to remain at liberty." A statute sanctioning such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly, construed in order to avoid deprivations of liberty without due process of law.

*Lynch v. Baxley*, 744 F.2d 1452, 1459 (11th Cir. 1984) (internal quotations omitted) (quoting *Covington v. Harris*, 419 F.2d 617, 623 (D.C. Cir. 1969)).

108. For a collection of relevant scholarship, see Zlotnick, *supra* note 79, at 402–03 n.109.

109. Keilitz et al., *supra* note 77, at 695–96.

110. On the issue of the patient's right to a written treatment plan, see, for example, *In re Maxwell*, 703 P.2d 574, 577 (Ariz. Ct. App. 1985) (holding that an order for treatment which committed the patient to a program of combined in-patient and out-patient treatment was void absent a showing that court was presented with an approved written treatment plan); see also *In re J.M.R.*, 505 A.2d 662, 663 (Vt. 1985) (finding that the trial court could not continue involuntary treatment on a nonhospitalized basis for an indeterminate time absent any finding that patient was dangerous to himself or others, or that he would become so if the treatment plan was discontinued). But see *In re Harhut*, 367 N.W.2d 628, 631 (Minn. Ct. App. 1985) (holding that the trial court erred in prescribing specific treatment programs, in ordering the county to prepare treatment reports and the hospital to submit a program plan to the court, and in ordering the county to create community placements in a commitment order).

111. See, e.g., *Scott v. Plante*, 641 F.2d 117, 130–31 (3d Cir. 1981) (explaining that the court has a "greater obligation to review constraints involuntarily imposed than it does treatments a state offers to willing patients" before assigning patients to the maximum security wing of a hospital), *vacated*, 458 U.S. 1101 (1982). For a subsequent case, see *In re James*, 547 N.E.2d 759, 761–62 (Ill. App. Ct. 1989) (finding that the absence of a report on the appropriateness and availability of alternative treatment facilities and a preliminary treatment plan required commitment reversal).

112. See, e.g., *Romeo v. Youngberg*, 644 F.2d 147, 165 (3d Cir. 1980) (declaring that "[a] right to treatment does not create a corresponding duty to submit to any treatment whatsoever"), *vacated*, 457 U.S. 307 (1982).

treatment,<sup>113</sup> prison transfer hearings,<sup>114</sup> and insanity acquittee release hearings.<sup>115</sup> A series of Illinois cases, for example, mandated that testimony as to mental disorder alone cannot satisfy statutory criteria requiring the preparation of reports on the appropriateness and availability of alternative treatment settings.<sup>116</sup>

Although the concept is not without ambiguity, and while its translation into individual involuntary civil commitment practice has, at times, been "problematic,"<sup>117</sup> its doctrinal importance as "one of the most important trends in mental health law"<sup>118</sup> cannot be questioned.<sup>119</sup>

113. See, e.g., *Rennie v. Klein*, 462 F. Supp. 1131, 1145 (D.N.J. 1978) (concluding that the patient, rather than the doctor, has the ultimate power to end treatment).

114. See *Jackson v. Peele*, (D.D.C. 1978), summarized in 22 Crim. L. Rep. (BNA) 2445 (stating that prisoner-patients are "entitled to the benefits of confinement in the least restrictive alternative"); see also *Johnson v. Levine*, 450 F. Supp. 648, 658 (D. Md. 1978) (declaring that only actively psychotic prisoners and those others who need immediate treatment should be transferred to an appropriate state mental institution), *aff'd in part and remanded*, 588 F.2d 1378 (4th Cir. 1978); *United States ex rel. Souder v. Watson*, 413 F. Supp. 711, 716-17 (M.D. Pa. 1976) (holding that the patient was deprived of equal protection of the law because he did not receive adequate notice and a full judicial hearing as is required for nonprisoners).

115. See *In re Portus*, 371 N.W.2d 871, 872-73 (Mich. Ct. App. 1985) (mandating that an insanity acquittee be given a hearing to consider alternatives to continued hospitalization); see also *In re Commitment of J.L.J.*, 481 A.2d 563, 569 (N.J. Super. Ct. App. Div. 1984) (declaring that the state must prove at a hearing that there exists a substantial risk of dangerous conduct within the reasonably foreseeable future to justify the further confinement of an insanity acquittee).

116. *In re Venegas*, 578 N.E. 2d 43, 45 (Ill. App. Ct. 1991); *In re Lamb*, 560 N.E.2d 422, 424-25 (Ill. App. Ct. 1990); *In re Blume*, 554 N.E.2d 1100, 1104 (Ill. App. Ct. 1990). But see *In re Robinson*, 601 N.E.2d 712, 718 (Ill. 1992) (reinstating commitment orders and finding oral testimony to be sufficient where the patient does not object to the lack of a written plan and the court is presented with all required information).

117. Bradley D. McGraw & Ingo Keilitz, *The Least Restrictive Alternative Doctrine in Los Angeles County Civil Commitment*, 6 WHITTIER L. REV. 35, 35 (1984). For instance, in *In re J.R.R.*, 427 N.W.2d 137, 140 (Wis. Ct. App. 1988), while the court endorsed *Lessard's* reasoning, it rejected a patient's argument that he was thus entitled to a court-ordered placement in an open ward unit. The court construed state law, WIS. STAT. ANN. § 51.20(13)(c)2 (West 1987), to require it to simply designate "the maximum level of inpatient facility in which treatment can occur," and it further found treatment decisions "beyond this due process consideration" to be "properly reserved for the medical authorities." *In re J.R.R.*, 427 N.W.2d at 140.

118. McGraw & Keilitz, *supra* note 117, at 36.

119. Interestingly, there have been very few legal developments around the question of the cognizability of treatment issues at the civil commitment hearing. See generally 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-8.1.

In a New Jersey intermediate appellate case, the court reasoned that the "single purpose" of a periodic review proceeding was "to determine whether [the patient] is entitled to be or should be discharged." *In re D.J.M.*, 386 A.2d 870, 872 (N.J. Super. Ct. App. Div. 1978). If, however, a patient wished to raise an adequacy of treatment issue, he could do so if he were to give notice to the court and "those who may be called upon to discharge their duties to the patient so that they may be given an opportunity to prepare for the proceeding and to appear and be heard." *Id.* at 872-73. In a subsequent decision,

#### D. *Post-Lessard Statutory Reform*<sup>120</sup>

As courts unhesitatingly endorsed the “least restrictive alternative” (LRA) concept in principle, state legislatures began to apply it to state mental health laws. By 1985, thirty-nine states required courts to consider alternatives to hospitalization at the time of involuntary civil commitment.<sup>121</sup> Of the few jurisdictions without such a direct statutory requirement, several grant the hearing court discretionary power to make such an inquiry,<sup>122</sup> and others do so by administrative regulation.<sup>123</sup>

While the term “LRA” is defined only in a handful of statutes,<sup>124</sup> and while “legislative attempts to graft it onto civil commitment laws and practice have [occasionally] met with pointed criticisms,”<sup>125</sup> the fact that so many states<sup>126</sup> have enacted some sort of LRA legislation inevitably reflects a trend that “likely will involve attempts to overcome superficiality and to articulate the means by which personal freedom and treatment

however, another panel of the same court remanded for further proceedings a periodic review case—involving an insanity acquittee—where the trial judge “may not have given due consideration to appellant’s need for more appropriate treatment of his mental condition.” *In re Commitment of J.L.J.*, 509 A.2d 184, 185–87 (N.J. Super. Ct. App. Div. 1985). Noting that the “right to treatment is an affirmative obligation on behalf of the State,” the court found that the evidence at the review hearing “certainly suggested that the treatment afforded to [appellant] was not providing him with a meaningful opportunity for cure or improvement,” and remanded “for such further proceedings as may be deemed necessary for consideration and implementation of an appropriate course of psychiatric treatment.” *Id.* at 186–87.

120. This section is adapted largely from 1 PERLIN, *MENTAL DISABILITY LAW*, *supra* note 1, § 2C-5.3b.

121. Keilitz et al., *supra* note 77, at 709–10 n.101. For a recent example, see N.J. STAT. ANN. § 30:4-27.11d(b)(2) (West 1997).

122. Keilitz et al., *supra* note 77, at 710 n.101.

123. N.Y. COMP. CODES R. & REGS. tit. 10, § 415.4 (1997). For a discussion of the impact of this section, see Bradley D. McGraw et al., *Civil Commitment in New York City: An Analysis of Practice*, 5 PACE L. REV. 259, 291–93 (1985). The scope of the LRA in New York is spelled out in constitutional terms in *In re Harry M.*, 468 N.Y.S.2d 359, 363–64 (N.Y. App. Div. 1983).

124. See Keilitz et al., *supra* note 77, at 710–11 n.102 (quoting statutes). See, e.g., GA. CODE ANN. § 37-3-1(10) (1995); KY. REV. STAT. ANN. § 202A.011(8) (Michie 1995); MO. ANN. STAT. § 630.005(21) (West 2000); N.M. STAT. ANN. § 43-1-3(D) (Michie 1993).

125. Keilitz et al., *supra* note 77, at 711. For criticisms, see Hoffman & Foust, *supra* note 94, at 1112–22; DAVID B. WEXLER, *MENTAL HEALTH LAW: MAJOR ISSUES* 144–54 (1981).

126. But see *In re Brown*, 493 A.2d 447, 451 (N.H. 1985) (finding that a statute, N.H. REV. STAT. ANN. § 135-B:32, V (1978), *repealed*, N.H. REV. STAT. ANN. § 135-C:40, V (1996) permits but does not require placement in the least restrictive alternative). See also *id.* (citing Thomas G. Gutheil et al., *The Inappropriateness of “Least Restrictive Alternative” Analysis for Involuntary Procedures with the Institutionalized Mentally Ill*, 11 J. PSYCHIATRY & L. 7, 12 (1983) (stating that courts are often confused by the meaning of the doctrine and frequently apply it erratically)).

effectiveness can be given equal consideration in the commitment process."<sup>127</sup>

### E. *The Significance of Youngberg*<sup>128</sup>

In expanding the least restrictive alternative concept beyond the involuntary civil commitment process, the Third Circuit Court of Appeals held in *Romeo v. Youngberg*<sup>129</sup> that involuntarily institutionalized persons with mental disabilities had a right to habilitation in the least restrictive alternative.<sup>130</sup> The U.S. Supreme Court, in vacating the Third Circuit's judgment,<sup>131</sup> declared a right to training and to "reasonably nonrestrictive confinement conditions,"<sup>132</sup> a phrase on which it neither elaborated nor further defined.<sup>133</sup>

The *Youngberg* decision, however, has had little impact on the application of the LRA doctrine to the commitment process, and most subsequent cases have construed state statutes carefully, with most courts continuing to demand relatively strict adherence to the appropriate statutory provisions.<sup>134</sup>

127. Keilitz et al., *supra* note 77, at 712. Cf. *In re Brungard*, 789 P.2d 683, 687-88 (Or. Ct. App. 1990) (finding "expanded criteria" for commitment not violative of equal protection clause).

128. This section is adapted from 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-5.3c.

129. 644 F.2d 147 (3d Cir. 1980), *vacated*, 457 U.S. 307 (1982).

130. *Id.* at 164-70.

131. *Youngberg v. Romeo*, 457 U.S. 307, 325 (1982).

132. *Id.* at 324.

133. Although the "reasonably nonrestrictive" phraseology continues to be occasionally cited, its contours have rarely been explored. 2 PERLIN, MENTAL DISABILITY LAW, *supra* note 3, § 3A-9.5, at 100 & nn.791-96.

134. See *Goebel v. Colorado Dep't of Insts.*, 764 P.2d 785, 797, 809 (Colo. 1988), *appeal after remand sub nom.* *Goebel v. Benton*, 830 P.2d 995 (Colo. 1992) (construing state law to provide treatment rights—including the LRA—for both involuntary and voluntary patients, but rejecting the plaintiffs *Youngberg* claims).

The Vermont Supreme Court, citing with approval an earlier decision by the Washington Supreme Court, set out its scheme by which the statutory criteria could be satisfied:

[V]oluntary alternatives must be considered first. The proposed patient should be encouraged to submit to an out-patient examination by a psychiatrist of his or her choice. Failing that, an out-patient examination could be scheduled by the court with a physician located as near as possible to the proposed patient's home. Although the latter alternative was unsuccessfully attempted in the present case, we believe additional options still remain. Among other less restrictive alternatives are "outreach home-visit evaluations." Under this alternative, the proposed patient would be visited at home by a psychiatrist for evaluation. Although this method may not always be practicable or successful, it may be appropriate in some cases. Another alternative to be considered by the trial court is the possibility of admitting expert opinion evidence at the commitment hearing in the absence of a psychiatric report, pursuant to [state statute and evidence rule].

### F. *The Meaning of Riggins*

In 1992, mental disability law jurisprudence seemed to take a dramatic turn in *Riggins v. Nevada*.<sup>135</sup> *Riggins* held that the use of antipsychotic drugs violated the defendant's right to a fair trial (at which he had raised the insanity defense),<sup>136</sup> focusing on the drugs' potential side-effects,<sup>137</sup> and construing its previous decision in *Washington v. Harper*<sup>138</sup>—limiting the rights of convicted prisoners to refuse medication<sup>139</sup>—to require an “overriding justification and a determination of medical appropriateness” prior to forcibly administering antipsychotic medications to a prisoner.<sup>140</sup> Justice Kennedy's concurrence focused on what might be called the “litigational side-effects” of antipsychotic drugs, and discussed the possibility that the drug use might have “compromise[d]” the substance of the defendant's trial testimony, his interaction with counsel, and his comprehension of the trial.<sup>141</sup>

While the court in *Riggins* did not set out a bright line test for determining the state's burden in involuntarily medicating a pretrial detainee at trial,<sup>142</sup> it did find that the burden would be

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*In re W.H.*, 481 A.2d 22, 25–26 (Vt. 1984) (citations omitted) (citing Mark Platt, Note, *The Due Process of Community Treatment of the Mentally Ill: A Case Study*, 59 TEX. L. REV. 1481, 1494 n.71 (1981)).

In North Dakota, the state supreme court has construed the operative statute to mandate a twofold inquiry: “(1) whether or not a treatment program other than hospitalization is adequate to meet the individual's treatment needs, and (2) whether or not an alternative treatment program is sufficient to prevent harm or injuries which an individual may inflict upon himself or others.” *In re J.S.*, 499 N.W.2d 604, 606 (N.D. 1993). In another case, the court held that while “[f]inancial circumstances may be relevant to “availability” of an alternative treatment program,” poverty is not a “criterion for commitment,” and accordingly reversed a commitment order where medical evidence revealed that, if financial assistance were available, the patient in question could be suitably treated in a nursing home. *In re R.M.*, 555 N.W.2d 798, 801 (N.D. 1996). For post-*Youngberg* constructions of the least restrictive alternative principle in a civil commitment context that do not cite *Youngberg*, see 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-5.3c, at 429 n.908.

135. 504 U.S. 127 (1992). See generally 2 PERLIN, MENTAL DISABILITY LAW, *supra* note 3, § 3B-8.3.

136. *Riggins*, 504 U.S. at 138.

137. *Id.* at 137 (noting that the antipsychotic drugs' side effects might have affected defendant *Riggins*' demeanor and testimony at trial, which could prejudice the jury's evaluation of him).

138. 494 U.S. 210 (1990).

139. *Id.* at 221–22.

140. *Riggins*, 504 U.S. at 135. See generally Marybeth Zientek, Note, *Riggins v. Nevada: Medicated Defendants and Courtroom Demeanor from the Jury's Perspective*, 30 AM. CRIM. L. REV. 215 (1992).

141. *Riggins*, 504 U.S. at 142 (Kennedy, J., concurring in the judgment).

142. See *id.* at 135–36 (discussing conditions under which the forced administration of drugs would satisfy due process).

met if the state proved either of the following: 1) the treatment was "medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others,"<sup>143</sup> or 2) there were no less intrusive means by which to obtain an adjudication of the defendant's guilt or innocence.<sup>144</sup>

*Riggins'* use of "less intrusive alternatives" language in this context was especially surprising. As the Supreme Court chose to bypass this construction in *Youngberg v. Romeo*,<sup>145</sup> it had appeared that there was simply no place for this doctrine in mental disability law. *Riggins* gave this construct new life in the surprising context of a criminal case.<sup>146</sup> Yet, there had been no indication in the years after *Riggins* was decided that lower courts were in any sort of hurry to revitalize least restrictive alternative law in this context.<sup>147</sup>

### G. *Perfunctory Involuntary Civil Commitment Hearings*<sup>148</sup>

Mental disability law is a topic dealt with on a daily basis by trial courts across the country in a series of unknown cases involving unknown litigants, where justice is often administered in assembly-line fashion.<sup>149</sup> Sophisticated legal arguments are rarely made, expert witnesses are infrequently called to testify, and lawyers all too often provide barely-perfunctory representation.<sup>150</sup> From this perspective, mental disability law is often invisible, both to the general public and to the academy.

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143. *Id.* at 135.

144. *Id.*

145. See 457 U.S. 307, 321 (1982) (agreeing that it is not appropriate for the courts to specify which alternative must be chosen, and that constitutional rights are protected by the exercise of sound professional judgment).

146. Perlin, *Promises by the Hour*, *supra* note 22, at 972-73 (proposing the importance of the "least restrictive alternative" concept as developed in *Riggins* in evaluating other involuntary treatment issues).

147. See 2 PERLIN, MENTAL DISABILITY LAW, *supra* note 3, § 3B-8.3, at 329 n.1354 (citing cases limiting *Riggins*).

148. This section is adapted from Michael L. Perlin, "Half-Wracked Prejudice Leaped Forth": *Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did*, 10 J. CONTEMP. LEGAL ISSUES 3, 19-22 (1999) [hereinafter Perlin, *Half-Wracked Prejudice*]. The Supreme Court has noted that the average time for involuntary civil commitment hearings was 9.2 minutes. *Parham v. J.R.*, 442 U.S. 584, 609 n.17 (1979).

149. See *Developments*, *supra* note 60, at 1265-71 (detailing the typical commitment procedures followed by state courts).

150. James A. Holstein, *Court-Ordered Incompetence: Conversational Organization in Involuntary Commitment Hearings*, 35 SOC. PROBS. 458, 464 (1988) (discussing the failure of the public defender system to provide effective defense in mental incompetency hearings).

The overwhelming number of cases involving mental disability law issues are "litigated" (quotation marks are used intentionally and provocatively) in pitch darkness. Involuntary civil commitment cases are routinely disposed of in a matter of minutes in closed courtrooms.<sup>151</sup> Often, constitutional doctrines articulated by the Supreme Court in mental disability law cases are ignored. The Supreme Court has stated, albeit in dicta, that "many psychiatric predictions of future violent behavior by the mentally ill are inaccurate."<sup>152</sup> Yet, such predictions are offered—frequently in minimalist ways that are subject to no meaningful cross-examination or challenge—daily in civil commitment courts across the country.<sup>153</sup>

State legislatures craft elaborate commitment codes, often mandating the need for an "overt act" as a predicate to commitment.<sup>154</sup> Yet, the expression of wishes, desires or the recitation of fantasies has been relied upon as a basis for commitment in individual cases.<sup>155</sup> Although the right to counsel is provided for in virtually every state commitment statute,<sup>156</sup> that right is often honored only in the breach; lawyers representing patients—and, just as important, those representing mentally disabled criminal defendants—often reflect Judge Bazelon's worst nightmare of "walking violations of the sixth Amendment."<sup>157</sup>

In short, the track record of counsel in representing persons subject to the involuntary civil commitment process—and of judges in conducting involuntary civil commitment hearings—has not been an inspiring one.<sup>158</sup> Counsel's inadequacies make the

151. See *Parham*, 442 U.S. at 609–10 n.17.

152. *Heller v. Doe*, 509 U.S. 312, 324 (1993).

153. See, e.g., 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-5.2, at 414–15.

154. *Id.* § 2A-4.5.

155. See, e.g., *People v. Stevens*, 761 P.2d 768, 775 & n.12 (Colo. 1988) (relying on presumed sexually inappropriate dress and manner—posing "provocatively in front of a mirror in the [hospital] day room in a tight-fitting leotard"—as sufficient evidence of a patient's danger to self to support his order of commitment); *State v. Hass*, 566 A.2d 1181, 1182–83 (N.J. Super. Ct. Law Div. 1988) (holding that a patient's sexual fantasies can serve as confirmatory evidence supporting his need for treatment under the state's Sex Offender Act).

156. See ROBERT M. LEVY & LEONARD S. RUBENSTEIN, *THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES* 74 (1996) (stating that courts have almost universally held that defendants in civil commitment hearings have right to counsel); see generally 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2B-3.1, at 197–201 (citing cases).

157. David L. Bazelon, *The Defective Assistance of Counsel*, 42 U. CIN. L. REV. 1, 2 (1973). For more recent cases discussing the inadequacy of counsel in the death penalty context, see Michael L. Perlin, "The Executioner's Face is Always Well-Hidden": *The Role of Counsel and the Courts in Determining Who Dies*, 41 N.Y.L. SCH. L. REV. 201, 204–07 (1996).

158. See generally Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the*



problems that I am addressing here even more difficult to resolve.

#### H. *The Right to Services in the Community*<sup>159</sup>

It is now necessary to turn to a mostly-moribund body of law—the constitutional dimensions of a right to community treatment—in an effort to determine the connection, if any, between least restrictive alternative law and the path that this litigation has taken.

1. *Background.* The theoretical underpinnings of a right to services in the community are found in the early cases that established both a right to treatment and a right to the least restrictive alternative in commitment decision making, and served as the initial groundwork for the attempt to structure a right to de-institutionalization and to community services.<sup>160</sup> Scholars suggested that predischarge planning and development of aftercare services were specific enforceable aspects of the constitutional right to treatment,<sup>161</sup> and cases proceeded on several parallel fronts—as outgrowths of right to treatment cases and challenges to involuntary civil commitment statutes,<sup>162</sup> as outgrowths of cases seeking to extend the least restrictive alternative doctrine beyond intrahospital decisionmaking,<sup>163</sup> and

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*Role of Counsel in Mental Disability Cases*, 16 LAW & HUM. BEHAV. 39 (1992) (discussing the inconsistency and inadequacy of counsel provided to defendants in commitment hearings).

159. This section is adapted from Michael L. Perlin, *The Voluntary Delivery of Mental Health Services in the Community*, in LAW, MENTAL HEALTH, AND MENTAL DISORDER 150, 152–54 (Bruce D. Sales & Daniel W. Shuman eds., 1996) [hereinafter Perlin, *Voluntary Delivery*].

160. Michael L. Perlin, *Rights of Ex-Patients in the Community: The Next Frontier?*, 8 BULL. AM. ACAD. PSYCHOL. & L. 33, 33 (1980).

161. Saphire, *supra* note 83, at 266–67 (arguing that the logical extension of a court's finding of an involuntary committed patient's right to treatment is her right to appropriate aftercare). For a subsequent, similar formulation, see, for example, Tim Exworthy, *Compulsory Care in the Community: A Review of the Proposals for Compulsory Supervision and Treatment of the Mentally Ill in the Community*, 5 CRIM. BEHAV. & MENTAL HEALTH 218, 237–38 (1995):

If patients are to be obliged to be subject to compulsory orders in the community as well as in hospital, to suffer further loss of rights, of privacy or to refuse to consent to treatment, then they are entitled to expect at least a reasonable standard of care. This places an obligation on authorities to provide that care.

*Id.*

162. See Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 421–22 (1982) (noting that various right to treatment cases have recognized the need for aftercare services).

163. See *id.* at 422–24 (arguing that courts have increasingly required consideration of the least restrictive alternative when adequate community facilities were not available).

as discrete cases seeking the promulgation of a discrete constitutional or statutory right to community care.<sup>164</sup>

2. *The Early Litigation.* Early cases thus found that, as part of the constitutional right to treatment, the state was obligated to provide "adequate transitional treatment and care for all patients released after a period of involuntary confinement."<sup>165</sup> The provision of these services was explicitly seen as a major "disincentive to unnecessary institutionalization."<sup>166</sup> Another early institutional rights case found that a settlement that had provided residents with the "least restrictive and most normal living conditions possible" required state officials to fund "natural home placements" for such residents where it was needed to meet the settlement's de-institutionalization criteria.<sup>167</sup>

The first case that focused explicitly on a right to community treatment found a statutory right to aftercare under local law, and ordered that the District of Columbia had a specific affirmative obligation to place those patients suitable for placement in "less restrictive alternatives" in community settings.<sup>168</sup> Although, operationally, compliance with this court decree was sporadic,<sup>169</sup> the legal principle was never seriously

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164. See *Dixon v. Weinberger*, 405 F. Supp. 974, 979-80 (D.D.C. 1975) (requiring a hospital to develop a plan for treatment of plaintiff patients in "suitable residential facilities under the least restrictive [alternative] conditions"); David Ferleger, *Anti-Institutionalization and the Supreme Court*, 14 RUTGERS L.J. 595, 598 & n.12 (1983) (noting that thousands of institutionalized individuals have used judicial means to secure more humane services in community facilities); David Ferleger & Penelope A. Boyd, *Anti-Institutionalization: The Promise of the Pennhurst Case*, 31 STAN. L. REV. 717, 732 (1979) (stating that "[m]uch progress has occurred in vindicating the legal rights of the mentally ill and mentally retarded").

165. *Wyatt v. Stickney*, 344 F. Supp. 373, 386 (M.D. Ala. 1972).

166. Patricia M. Wald & Paul R. Friedman, *The Politics of Mental Health Advocacy in the United States*, 1 INT'L J.L. & PSYCHIATRY 137, 146 (1978).

167. *N.Y. State Ass'n of Retarded Children, Inc. v. Carey*, 492 F. Supp. 1099, 1110 (E.D.N.Y. 1980).

168. See *Dixon*, 405 F. Supp. at 979. See also Melissa G. Warren & Robert R. Moon, *Dixon: In the Absence of Political Will, Carry a Big Stick*, 18 LAW & PSYCHOL. REV. 329, 330 (1994) (noting that *Dixon* was the first de-institutionalization case to order community-based treatment).

169. See 2 PERLIN, *MENTAL DISABILITY LAW* (1st ed.), *supra* note 76, § 7.06; *Landmark Agreement to Create Community Mental Health System*, 13 MENTAL & PHYSICAL DISABILITY L. REP. 229 (1989); *Accord Reached on Community Services Plan for D.C. Patients*, 40 HOSP. & COMMUNITY PSYCHIATRY 973 (1989) (reporting that an agreement had finally been reached in the landmark *Dixon* case, thirteen years after the court's order). The litigation continues to this day. See *Dixon v. Barry*, 967 F. Supp. 535, 555 (D.D.C. 1997) (appointing a receiver to oversee the Commission on Mental Health Services after twenty-two years of unsuccessful compliance). See generally Warren & Moon, *supra* note 168, at 330 (highlighting the discrepancy and delay between the court's ruling in *Dixon* and the implementation of its orders).

challenged and subsequent cases in other jurisdictions settled on terms that were close to those ordered in the *Dixon* decree.<sup>170</sup> A somewhat different approach was put forth in New Jersey, where the state Supreme Court ruled that individuals who no longer met involuntary civil commitment criteria, but for whom there was no adequate or suitable placement, would be entitled to special placement hearings at which the court would make inquiry as to "the needs of the individual for custodial and supportive care, the desires of the individual regarding placement, the type of facility that would provide the needed level of care in the least restrictive manner, the availability of such placement, [and] the efforts of the State to locate such placement."<sup>171</sup>

Finally, litigation sought the declaration of a constitutional right to de-institutionalization and community services. Merging arguments in support of constitutional rights to treatment and the least restrictive alternative,<sup>172</sup> this theory argued that, where further inpatient confinement is "predictably antitherapeutic, further confinement must be deemed to effect a continuing violation of due process."<sup>173</sup> When this theory was advanced in the case of *Halderman v. Pennhurst State School and Hospital*,<sup>174</sup> it was, at first, remarkably successful. First, the district court found that conditions at the Pennhurst facility (an institution that was "inappropriate and inadequate for the habilitation of the retarded"),<sup>175</sup> violated residents' rights to minimally adequate habilitation,<sup>176</sup> their right to freedom from harm,<sup>177</sup> their right to

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170. See, e.g., *Wuori v. Zitnay*, Civ. No. 75-80-P (D. Me. July, 14 1978); *Brewster v. Dukakis*, 544 F. Supp. 1069 (D. Mass. 1982) (mem.), *aff'd as modified*, 786 F.2d 16 (1st Cir. 1986).

171. *In re S.L.*, 462 A.2d 1252, 1258 (N.J. 1983); Michael L. Perlin, "Discharged Pending Placement": *The Due Process Rights of the Nondangerous Institutionalized Mentally Handicapped with "Nowhere to Go,"* 5 DIRECTIONS IN PSYCHIATRY 1, 2 (1985) [hereinafter Perlin, *Discharged Pending Placement*]. On the "discharged pending placement" (DPP) status (and the successor "conditions extended placing placement" (CEPP) status) in general, see 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-6.3.

172. See *Ferleger & Boyd*, *supra* note 164, at 739 (arguing that involuntarily committed patients have a right to habilitation which can never be adequately provided by mental institutions and that, therefore, the only constitutionally acceptable method of treatment is that of the least restrictive alternative).

173. *Saphire*, *supra* note 83, at 286 (footnote omitted).

174. 446 F. Supp. 1295 (E.D. Pa. 1978), *aff'd in part and rev'd in part*, 612 F.2d 84 (3d Cir. 1979), *rev'd*, 451 U.S. 1 (1981).

175. *Id.* at 1304.

176. *Id.* at 1318. Although there are self-evidently great differences between facilities established to care for persons with mental retardation and those so established for persons with mental illness, the case law has rarely focused on these differences, and most important cases have been cited interchangeably in subsequent decisions without regard to the particular handicapping condition of the institutionalized persons in

"[n]on-[d]iscriminatory [h]abilitation,"<sup>178</sup> as well as state and federal statutory rights to minimally adequate habilitation,<sup>179</sup> and ordered the facility closed, finding that every resident removed from the facility had to be "accommodated in a community facility which [would] provide minimally adequate habilitation."<sup>180</sup>

On appeal, the Third Circuit substantially affirmed, but on a nearly totally different legal basis, finding that the federal Developmentally Disabled Assistance and Bill of Rights Act (DD Act) provided an enforceable statutory right to treatment in the least restrictive alternative setting.<sup>181</sup> On the other hand, it disagreed with the trial court's conclusion that the facility needed to be closed, believing that, for some patients, such a transfer to community settings "might be too unsettling a move,"<sup>182</sup> and ordering a remand for individual determinations as to the appropriateness of "an improved Pennhurst for each such patient."<sup>183</sup>

Thus, by the early 1980s, it appeared as if the concept of a right to community services was one in good currency. Courts appeared willing to premise this right on both constitutional and statutory bases, and appeared comfortable with seeing it as the logical next step in right to treatment and right to least restrictive alternative litigation.<sup>184</sup> The decisions by the Supreme Court in *Youngberg* and in *Pennhurst*, however, made it clear that this vision was not shared by that court.<sup>185</sup>

3. *The Supreme Court Speaks.* The Supreme Court first heard the state's appeal from the *Pennhurst* case in 1981.<sup>186</sup> Per Justice Rehnquist, it rejected out of hand the Third Circuit's methodology, and ruled that the DD Act did not create enforceable rights.<sup>187</sup> The Court conceived of the statute as merely

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question.

177. *Id.* at 1320.

178. *Id.* at 1321-22.

179. *Id.* at 1322-24.

180. *Id.* at 1325, 1327.

181. *Halderman v. Pennhurst State Sch. & Hosp.*, 612 F.2d 84, 107 (3d Cir. 1979), *rev'd*, 451 U.S. 1 (1981).

182. *Id.* at 114.

183. *Id.*

184. See Keilitz et al., *supra* note 77, at 692-93 (describing the use of the "least restrictive alternative" concept to implement the policy of de-institutionalization of the mentally retarded); see also Ferleger, *supra* note 164, at 625 (noting that the right to habilitation for the mentally retarded has gained statutory and judicial recognition).

185. Refer to Part II.E *supra*.

186. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981).

187. *Id.* at 18, 31-32. In the DD Act, Congress made specific findings that

a voluntary "federal-state grant program" through which the federal government could provide financial assistance to states to aid in the creation of programs to treat developmentally disabled persons.<sup>188</sup> The Court further found that nothing in the legislative history of the Act suggested that Congress intended to require the states to provide "appropriate treatment" in the "least restrictive environment" to mentally retarded citizens.<sup>189</sup> It then remanded the case to the Third Circuit to consider other arguments that had been made by the plaintiffs upon which the lower court had not yet ruled.<sup>190</sup>

On remand, the Third Circuit reinstated in its entirety its initial ruling, but on an entirely different basis. Premising its holding solely on Pennsylvania law, the court found that state residents were entitled to treatment in the least restrictive alternative setting, and that such a formulation meant "the mentally retarded person and [his or her] family shall have the right to live a life as close as possible to that which is typical for the general population."<sup>191</sup> Again, state officials appealed this decision to the Supreme Court.<sup>192</sup>

Then, in 1984, the Supreme Court once more reversed the Third Circuit in *Pennhurst* on Eleventh Amendment grounds.<sup>193</sup>

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"[i]ndividuals with developmental disabilities have a right to appropriate treatment, services, and habilitation" and that treatment should be provided "in the setting that is least restrictive of the individual's personal liberty." 42 U.S.C. § 6009(1)-(2) (1994 & Supp. IV 1998).

188. *Pennhurst*, 451 U.S. at 11.

189. *Id.* at 18.

190. *Id.* at 31.

191. *Halderman v. Pennhurst State Sch. & Hosp.*, 673 F.2d 647, 652 (3d Cir. 1982), *rev'd*, 465 U.S. 89 (1984) (quoting *In re Schmidt*, 429 A.2d 631, 635 (Pa. 1981)).

192. *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89 (1984).

193. *Id.* at 120. The Eleventh Amendment reads, in pertinent part: "The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State . . ." U.S. CONST. amend. XI.

Decisions construing this amendment have been characterized as "a wonderland of judicially created and perpetuated fiction and paradox." *Spicer v. Hilton*, 618 F.2d 232, 235 (3d Cir. 1980). See generally Martin A. Schwartz, *The Eleventh Amendment and State Law Claims*, 18 CLEARINGHOUSE REV. 151, 151-52 (1984) (summarizing the Court's reasoning in the second *Pennhurst* case).

*Pennhurst* continues to be cited and analyzed regularly by commentators. See, e.g., J. Brian King, *The State Political Processes Theory of the 11th Amendment*, 19 REV. LITIG. 355, 395 (2000); Roger C. Hartley, *The Alden Trilogy: Praise and Protest*, 23 HARV. J.L. & PUB. POL'Y 323, 377-92 (2000); James E. Pfander, *Once More Unto the Breach: Eleventh Amendment Scholarship and the Court*, 75 NOTRE DAME L. REV. 817, 825 (2000).

The Supreme Court has since granted certiorari in (and in late October 2000, heard oral argument in) *Garrett v. University of Alabama at Birmingham Board of Trustees*, 193 F.3d 1214 (11th Cir. 1999) (states do not have Eleventh Amendment sovereign immunity in ADA cases), *cert. granted in part*, 120 S. Ct. 1669 (2000). For a

In what was “clearly the Court’s most bitterly split institutional decision of the century,”<sup>194</sup> the Court ruled that such actions were entirely barred by the Eleventh Amendment,<sup>195</sup> and that a federal court’s instructing state officials how to conform their conduct to comply with state law was an “intrusion on state sovereignty” that conflicted squarely with “principles of federalism.”<sup>196</sup>

These cases reflect a Supreme Court vision of the state’s obligation to provide services for persons with mental disabilities that is drastically at odds with the one offered by advocates representing such persons. While the persons with mental disabilities at risk in *Pennhurst* and *Youngberg* may not have been the Court’s specific targets in its decisions, the cases are clearly linked to the Court’s desire “to ban ‘public law’ litigation in general, and ‘institutional’ litigation in particular, from federal tribunals,”<sup>197</sup> as well as its ongoing transformation of the Court’s role “from the guardian of individual rights to the guardian of majority rule.”<sup>198</sup> Within months of the second *Pennhurst* decision, commentators had thus gloomily concluded that the Court’s opinion had “distressing tactical implications for proponents of a right to community treatment for mental patients,”<sup>199</sup> and predicted that the case would foreclose further federal involvement in institutional reform and de-institutionalization litigation.<sup>200</sup>

And so it appeared, at least until the passage of the Americans with Disabilities Act.

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discussion of the oral argument in *Garrett*, see Tony Mauro, *High Court Weighs Whether ADA Applies to States*, N.Y. L.J., Oct. 12, 2000, at 1, available at WL 10/12/2000 NYLJ 1.

194. See 2 PERLIN, *MENTAL DISABILITY LAW* (1st ed.), *supra* note 76, § 7.15, at 627; David Rudenstine, *Pennhurst and the Scope of Federal Judicial Power to Reform Social Institutions*, 6 CARDOZO L. REV. 71, 72 (1984).

195. *Pennhurst*, 465 U.S. at 120.

196. *Id.* at 106.

197. George D. Brown, *Beyond Pennhurst—Protective Jurisdiction, the Eleventh Amendment, and the Power of Congress to Enlarge Federal Jurisdiction in Response to the Burger Court*, 71 VA. L. REV. 343, 344 (1985) (footnotes omitted).

198. Suzanna Sherry, *Issue Manipulation by the Burger Court: Saving the Community from Itself*, 70 MINN. L. REV. 611, 663 (1986).

199. Geoffrey Mort, Note, *Establishing a Right to Shelter for the Homeless*, 50 BROOK. L. REV. 939, 954 (1984).

200. Elizabeth M. Pezzetti, Comment, *Reinstitutionalization of the Mentally Retarded*, 32 WAYNE L. REV. 1105, 1108 (1986).

III. THE AMERICANS WITH DISABILITIES ACT<sup>201</sup>A. *The Statute*

The Americans with Disabilities Act (ADA) has been hailed by advocates for persons with disabilities as “a breathtaking promise,”<sup>202</sup> “the most important civil rights act passed since 1964,”<sup>203</sup> and as the “Emancipation Proclamation for those with disabilities.”<sup>204</sup> It is, without question, Congress’s most innovative attempt to address the pervasive problem of discrimination against physically and mentally handicapped citizens<sup>205</sup> by providing, in the words of a congressional committee, “a clear and comprehensive national mandate to end discrimination against individuals with disabilities.”<sup>206</sup> The ADA provides basically the same bundle of protections for persons with disabilities as the Civil Rights Acts of the 1960s did for citizens of color<sup>207</sup> with clear, strong, and enforceable standards.<sup>208</sup>

The language that Congress chose to use in its introductory fact-findings is of extraordinary importance.<sup>209</sup> Its specific finding

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201. This section is adapted from MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* 175–204 (2000) [hereinafter PERLIN, *THE HIDDEN PREJUDICE*]. See generally Michael L. Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes be Undone?*, 8 J.L. & HEALTH 15 (1993–94) [hereinafter Perlin, *Sanist Attitudes*]; PERLIN, *MENTAL DISABILITY LAW* (Cum. Supp. 1999), *supra* note 29, § 6.44A, at 16–83; Perlin, *Promises by the Hour*, *supra* note 22; Perlin, *Maggie’s Farm*, *supra* note 29; Perlin, *Misdemeanor Outlaw*, *supra* note 96.

202. Bonnie Milstein et al., *The Americans with Disabilities Act: A Breathtaking Promise for People with Mental Disabilities*, 24 CLEARINGHOUSE REV. 1240 (1991).

203. Kent Jenkins, Jr., *Spotlight Finds Hoyer*, WASH. POST, May 28, 1990, at D1, cited in Kimberly A. Ackourey, Comment, *Insuring Americans with Disabilities: How Far Can Congress go to Protect Traditional Practices?*, 40 EMORY L.J. 1183, 1183 & n.1 (1991).

204. *Americans with Disabilities Act of 1990: Summary and Analysis*, 4 Lab. Rel. Wk. (BNA) 29, Special Supplement, at S-5 (July 18, 1990), cited in Ackourey, *supra* note 203, at 1183 & n.2 (statement by the Bill’s sponsors). See also, e.g., Sandra K. Law, Comment, *The Americans with Disabilities Act of 1990: Burden on Business or Dignity for the Disabled?*, 30 DUQ. L. REV. 99, 114 (1991) (concluding that the ADA is a “solid and positive step toward making this country a better nation”).

205. PERLIN, *MENTAL DISABILITY LAW* (Cum. Supp. 1999), *supra* note 29, § 6.44A, at 16 (proclaiming that the ADA stands as Congress’s “most innovative attempt to address the pervasive problem of discrimination against physically and mentally handicapped citizens”).

206. H.R. REP. NO. 101-485 (III), at 23 (1990), reprinted in 1990 U.S.C.C.A.N. 445–46.

207. For a comprehensive overview, see Bonnie P. Tucker, *The Americans with Disabilities Act of 1990: An Overview*, 22 N.M. L. REV. 13 (1992).

208. See, e.g., *id.* at 43–48, 63–64, 93–95, 101–02 (discussing enforcement provisions). Cf. Pamela S. Karlan & George Rutherglen, *Disabilities, Discrimination, and Reasonable Accommodation*, 46 DUKE L.J. 1, 2–3 (1996) (reading the ADA to provide more protections than do other civil rights acts).

209. On the “shocking and eye-opening” nature of these findings, see Amy Scott

that individuals with disabilities are a "discrete and insular minority... subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness"<sup>210</sup> is not just precatory flag-and-apple-pie rhetoric.<sup>211</sup> This language—granted "the force of law"<sup>212</sup>—was carefully chosen; it comes from the heralded "footnote 4" of *United States v. Carolene Products*, which has served as the springboard for nearly a half century of challenges to state and municipal laws that have operated in discriminatory ways against other minorities,<sup>213</sup> and reflects a congressional commitment to provide "protected class" status for persons with disabilities.<sup>214</sup> This in turn forces courts to employ a "compelling

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Loundes, Note, *The Americans with Disabilities Act of 1990: A Congressional Mandate for Heightened Judicial Protection of Disabled Persons*, 44 FLA. L. REV. 417, 446 (1992).

210. 42 U.S.C. § 12101(a)(7) (1994).

211. Cf. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 11 (1981) (stating that the rights language in the DD Act and Bill of Rights Act, 42 U.S.C. §§ 6010–6081 (1994 & Supp. III 1998 & Supp. IV 1999), simply created a "federal-state" granting statute, and did not vest individuals with developmental disabilities with a legally enforceable cause of action). Refer to notes 193–200 *supra* and accompanying text. This conclusion was criticized as "absurd" and "objectionable" in an article co-authored by plaintiffs' lead counsel in the *Pennhurst* case. David A. Ferleger & Patrice Maguire Scott, *Rights and Dignity: Congress, the Supreme Court, and People with Disabilities After Pennhurst*, 5 W. NEW ENG. L. REV. 327, 350 (1983). On the question of whether key sections of the ADA will be seen as little more than hortatory language, see Perlin, *Promises by the Hour*, *supra* note 22, at 955. For a survey of all commentary, see 2 PERLIN, MENTAL DISABILITY LAW (1st ed.), *supra* note 76, § 7.13.

212. James B. Miller, *The Disabled, the ADA, and Strict Scrutiny*, 6 ST. THOMAS L. REV. 393, 413 (1994).

213. *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152–53 n.4 (1938). I discuss the impact of this footnote on the development of mental disability law in Michael L. Perlin, *On "Sanism"*, 46 SMU L. REV. 373, 380–81 & n.51 (1992) [hereinafter Perlin, *On "Sanism"*], and in 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 1-2.1, at 7 & n.31.

On the significance of the *Carolene Products* language to the ADA, see, for example, Leonard S. Rubenstein, *Ending Discrimination Against Mental Health Treatment in Publicly Financed Health Care*, 40 ST. LOUIS U. L.J. 315, 339 (1996) (explaining that the ADA's invocation of the *Carolene Products* footnote demonstrates justification for employing "heightened judicial scrutiny"); Susan Lee, Heller v. Doe: *Involuntary Civil Commitment and the "Objective" Language of Probability*, 20 AM. J.L. & MED. 457, 467–68 n.90 (1994) (noting that the language of the ADA reflects congressional intent to identify persons with disabilities as a group "deserving heightened scrutiny"); Lisa A. Montanaro, Comment, *The Americans with Disabilities Act: Will the Court Get the Hint? Congress' Attempt to Raise the Status of Persons with Disabilities in Equal Protection Cases*, 15 PACE L. REV. 621, 663 (1995) (observing that by adopting the ADA, Congress attempted to utilize the *Carolene Products* theory to imply that a "heightened level of scrutiny" should be used in ADA cases).

214. See, e.g., Montanaro, *supra* note 213, at 663–64 (proclaiming that Congress intended to transform persons with disabilities into a suspect class for purposes of constitutional and statutory interpretation); Loundes, *supra* note 209, at 446 ("Congress clearly intended to create a new protected class—the disabled."); Miller, *supra* note 212, at 412 (declaring that Congress applied a "suspect class" test in ADA statutory language); Phyllis Coleman & Ronald A. Shellow, *Ask About Conduct, Not Mental Illness: A Proposal for Bar Examiners and Medical Boards to Comply with the ADA and*



state interest" or "strict scrutiny" test in considering statutory and regulatory challenges to allegedly discriminatory treatment.<sup>215</sup> In *City of Cleburne v. Cleburne Living Center, Inc.*,<sup>216</sup> the Supreme Court ruled that persons with mental retardation were neither a suspect class nor a quasi-suspect class for purposes of equal protection analysis.<sup>217</sup> In supporting its conclusion, the Court noted that a contrary decision would have made it difficult to distinguish other groups such as persons with mental illness "who have perhaps immutable disabilities setting them off from others, who cannot themselves mandate the desired legislative responses, and who can claim some degree of prejudice from at least part of the public at large."<sup>218</sup> The law's invocation of the full "sweep of congressional authority, including the power to enforce the fourteenth amendment"<sup>219</sup> simply means that any violation of the ADA must be read in the same light as a violation of the equal protection clause of the Constitution, guaranteeing—for the first time—that this core constitutional protection will finally be made available to persons with disabilities.<sup>220</sup>

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*Constitution*, 20 J. LEGIS. 147, 151 n.23 (1994) (stating "the ADA treats disabled persons as a suspect class").

In a trilogy of employment cases, the Supreme Court has narrowed the category of persons who are to be treated as "disabled" under the ADA. See *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 475 (1999) (concluding that the determination of disability under the ADA should be made with reference to measures mitigating the impairment, including, in this instance, corrective lenses); *Albertson's, Inc. v. Kirkingburg*, 527 U.S. 555, 558 (1999) (finding that the ADA does not require an employer to "justify enforcing [an otherwise applicable federal safety] regulation solely because its standard may be waived in an individual case"); *Murphy v. UPS, Inc.*, 527 U.S. 516, 518–19 (1999) (upholding a Tenth Circuit decision to consider the petitioner in his medicated state when deciding that his hypertension did not "substantially limit" a major life activity). Nothing in these decisions, however, goes to the question of how the Court would construe discrimination cases involving individuals found to be "disabled" within the ADA's meaning.

215. On the relationship between this language and the heightened scrutiny requirement, see, for example, *Crowder v. Kitagawa*, 842 F. Supp. 1257, 1264 (D. Haw. 1994) (assuming an application of strict scrutiny in ADA cases) and William Christian, Note, *Normalization as a Goal: The Americans with Disabilities Act and Individuals with Mental Retardation*, 73 TEX. L. REV. 409, 424 (1994) (contending that laws affecting persons with disabilities should be subject to heightened scrutiny).

216. 473 U.S. 432 (1985).

217. *Id.* at 435.

218. *Id.* at 445.

219. 42 U.S.C. § 12101(b)(4) (1994).

220. See, e.g., Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMP. L. REV. 393, 434 (1991) ("[Congressional] findings indicate unambiguously that Congress considered disability classifications to be just as serious and just as impermissible as racial categorizations that are given 'strict' or 'heightened' scrutiny, sustainable by the courts only if they are tailored to serve a 'compelling' governmental interest."). Cook's article is cited approvingly in, *inter alia*, *Muller v.*

Individuals in in-patient psychiatric hospitals comprise a population that is classically voiceless and friendless, with few contacts in the "free world."<sup>221</sup> It is a population whose disenfranchisement starkly mirrors the sort of powerlessness and marginalization spoken to by the Supreme Court in *Carolene Products* and, of course, spoken to by Congress in the ADA's initial findings section.<sup>222</sup>

The legislative history is remarkably skimpy, and speaks to only two relevant considerations. First, it reflects congressional awareness of the pernicious danger of stereotyping behavior. It makes this clear through its heavy reliance on the Supreme Court's language in *School Board of Nassau County v. Arline*<sup>223</sup> that "society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment."<sup>224</sup> Congress stressed that its including in the definition of disability an individual who is *regarded as being impaired*<sup>225</sup> acknowledges this teaching about the power of myths.<sup>226</sup>

Thus, employment decisions cannot be based on "paternalistic views" of what is best for a person with a disability.<sup>227</sup> The employment title of the ADA was thus designed, in significant part, to prevent employers from relying on presumptions, stereotypes, misconceptions and unfounded fears in making employment decisions,<sup>228</sup> and as a means of breaking the chain of misperception that disabled individuals are a

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*Costello*, 187 F.3d 298, 308 (2d Cir. 1999); *Kathleen S. v. Department of Public Welfare*, 10 F. Supp. 2d 460, 467 (E.D. Pa. 1998); *Muller v. Hotsy Corp.*, 917 F. Supp. 1389, 1402 (N.D. Iowa 1996); *Valentine v. American Home Shield Corp.*, 939 F. Supp. 1376, 1388 (N.D. Iowa 1996); *Fink v. Kitzman*, 881 F. Supp. 1347, 1368 (N.D. Iowa 1995); *Hutchinson v. UPS, Inc.*, 883 F. Supp. 379, 387 (N.D. Iowa 1995); and *Heather K. v. City of Mallard*, 887 F. Supp. 1249, 1263 (N.D. Iowa 1995).

221. See, e.g., Curran, *supra* note 62, at 274-77 (providing an historical background on the institutionalization of mentally ill persons in the United States).

222. Rubenstein, *supra* note 213, at 338-39, 350.

223. 480 U.S. 273, 277 (1987) (finding that an individual with tuberculosis is a "handicapped individual" under 29 U.S.C. § 794 (Section 504 of the Rehabilitation Act of 1973)).

224. *Id.* at 284.

225. 42 U.S.C. § 12102(2)(C) (1994).

226. H.R. REP. NO. 101-485 (II), at 53 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 335; see also *id.* at 55, *reprinted in* 1990 U.S.C.C.A.N. 303, 337.

227. *Id.* at 74, *reprinted in* 1990 U.S.C.C.A.N. 303, 356.

228. *Id.* at 30, *reprinted in* 1990 U.S.C.C.A.N. 303, 311 (stating that discrimination against persons with disabilities "often results from false presumptions, generalizations, misperceptions, patronizing attitudes, ignorance, irrational fears, and pernicious mythologies").

"permanently helpless and separate class, unable to work or otherwise contribute to society."<sup>229</sup>

Second, the history of the "direct threat" section—again relying on *Arline*—specifies that, for persons with mental disabilities, the employer must identify "the specific behavior on the part of the individual that would pose the anticipated direct threat," and that the determination must be based on such behavior, "not merely on generalizations about the disability."<sup>230</sup> In such a case, there must be "objective evidence . . . that the person has a recent history of committing overt acts or making threats which caused harm or which directly threatened harm."<sup>231</sup>

Persons with mental disabilities have faced the brunt of discrimination for years. Surveys show that mental disabilities are the most negatively perceived of all disabilities.<sup>232</sup> Mentally

229. Elizabeth Clark Morin, Note, *Americans with Disabilities Act of 1990: Social Integration Through Employment*, 40 CATH. U. L. REV. 189, 189, 212 (1990). See also Peter David Blanck, *Empirical Study of the Employment Provisions of the Americans with Disabilities Act: Methods, Preliminary Findings, and Implications*, 22 N.M. L. REV. 119, 129 (1992) (describing employers' myths in this context). See generally Peter David Blanck, *The Emerging Work Force: Empirical Study of the Americans with Disabilities Act*, 16 J. CORP. L. 693, 696 (1991) (providing empirical data on employment-related aspects of the ADA); W. Robert Gray, *The Essential-Function Limitation of the Civil Rights of People with Disabilities and John Rawls's Concept of Social Justice*, 22 N.M. L. REV. 295, 317 (1992) (discussing the significance of "misinformed stereotypes").

230. H.R. REP. NO. 101-485 (II), at 56-57 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 338-39. See also PERLIN, *THE HIDDEN PREJUDICE*, supra note 201, at 178 n.31 ("The determination that an individual with a disability will pose a safety threat to others must be made on a case-by-case basis and must not be based on generalizations, misperceptions, ignorance, irrational fears, patronizing attitudes, or pernicious mythologies") (quoting Cheryl Fells, *Employee Benefit Plan Implications of the Americans with Disabilities Act*, in *Employer Compliance with the Americans with Disabilities Act of 1990*, at 414 (PLI Corp. Practice Course Handbook Series No. B4-6947, 1990)); Renée L. Cyr, Note, *The Americans with Disabilities Act: Implications for Job Reassignment and the Treatment of Hypersusceptible Employees*, 57 BROOK. L. REV. 1237, 1273 (1992) (quoting H.R. REP. NO. 101-485 (II) for the proposition that generalized fear about risks from the employment environment "cannot be used by an employer to disqualify a person with a disability").

231. H.R. REP. NO. 101-485 (III), at 45-46 (1990), reprinted in 1990 U.S.C.C.A.N. 445, 468-69. This language closely parallels that of the Fair Housing Act Amendments of 1988, under which an otherwise qualified disabled person can be excluded from the definition of handicap only where a landlord can establish that the individual's tenancy would be a "direct threat to the health or safety of other individuals." 42 U.S.C. § 3604(e)(9) (1994). To trigger this section, the legislative history stressed that "there must be objective evidence from the person's prior behavior that the person has committed overt acts which caused harm or which directly threatened harm." H.R. REP. NO. 100-711, at 29 (1988), reprinted in 1988 U.S.C.C.A.N. 2173, 2190. See Richard B. Simring, Note, *The Impact of Federal Antidiscrimination Laws on Housing for People with Mental Disabilities*, 59 GEO. WASH. L. REV. 413, 441 (1991) (pointing to the legislative history of the ADA showing Congress anticipated this proof would have to overcome a plaintiff's prima facie case establishing there existed a reasonable accommodation the landlord had not provided).

232. Jane West, *The Social and Policy Context of the Act*, in *THE AMERICANS WITH*

disabled individuals have been denied jobs, refused access to apartments in public housing or entry to places in public accommodation, and turned down for participation in publicly-funded programs because they appear "strange" or "different."<sup>233</sup> A series of behavioral myths has emerged suggesting that mentally disabled persons are deviant, worth less than "normal" individuals, disproportionately dangerous, and presumptively incompetent.<sup>234</sup> Yet, the ADA barely speaks directly to *these* myths or to the special problems faced by persons with mental disabilities in attempting to combat them.<sup>235</sup>

Although a smattering of early ADA case law dealt with issues involving institutional settings and mental disability,<sup>236</sup> all prior developments must be seen as a prelude to the Court's decision in *Olmstead*.

#### B. *Olmstead v. L.C.*<sup>237</sup>

In *Olmstead*, the Court qualifiedly affirmed a decision by the Eleventh Circuit that had provided the first coherent answer to the question of the right of institutionalized persons with mental

DISABILITIES ACT: FROM POLICY TO PRACTICE 3, 9 (Jane West ed., 1991), *reprinted in* 69 MILLBANK Q. 3 (1991) (citing A.J. ARANGIO, *BEHIND THE STIGMA OF EPILEPSY: AN INQUIRY INTO THE CENTURIES-OLD DISCRIMINATION AGAINST PERSONS WITH EPILEPSY* (1979)).

233. Simring, *supra* note 231, at 422. *See also* Cook, *supra* note 220, at 399–414, 424 (recounting the history of government-imposed segregation and degradation of persons with disabilities). Particularly cruel examples are listed in Tucker, *supra* note 207, at 16–17.

234. *See, e.g.,* Perlin, *On "Sanism," supra* note 213, at 393–97 (citing, *inter alia*, SANDER L. GILMAN, *DIFFERENCE AND PATHOLOGY: STEREOTYPES OF SEXUALITY, RACE, AND MADNESS* (1985); Steven J. Schwartz, *Damage Actions as a Strategy for Enhancing the Quality of Care of Persons with Mental Disabilities*, 17 N.Y.U. REV. L. & SOC. CHANGE 651, 681 (1989–90); Michael L. Perlin, *Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence*, 40 CASE W. RES. L. REV. 599, 693–96 (1989–90); Linda A. Teplin, *The Criminality of the Mentally Ill: A Dangerous Misconception*, 142 AM. J. PSYCHIATRY 593, 597–98 (1985); and Thomas Grisso & Paul S. Appelbaum, *Mentally Ill and Non-Mentally-Ill Patients' Abilities to Understand Informed Consent Disclosures for Medication*, 15 LAW & HUM. BEHAV. 377, 385–86 (1991)).

235. On the way that public perceptions of mental illness and the accompanying stigma perpetuate inadequate treatment of the mentally ill, see generally Wayne Edward Ramage, *The Pariah Patient: The Lack of Funding for Mental Health Care*, 45 VAND. L. REV. 951 (1992).

236. *See* Perlin, *THE HIDDEN PREJUDICE, supra* note 201, at 188 (discussing, *inter alia*, the meaning of *Helen L. v. DiDario*, 46 F.3d 325, 331 (3d Cir. 1995)). On the significance of *Pennsylvania Department of Corrections v. Yeskey*, 524 U.S. 206, 213 (1998) (applying the ADA to state prisons), see Michael L. Perlin, *Hidden Agendas and Ripple Effects: Implications of Four Recent Supreme Court Decisions for Forensic Psychiatrists*, 2 J. FORENSIC PSYCHOL. PRAC. 33 (2000) [hereinafter Perlin, *Hidden Agendas*].

237. 527 U.S. 581 (1999). This section is adapted from PERLIN, *MENTAL DISABILITY LAW* (Cum. Supp. 1999), *supra* note 29, § 6.44AA. *See also* Perlin, *Misdemeanor Outlaw, supra* note 96.

disabilities to community services under the ADA.<sup>238</sup> There, the Court of Appeals had found that the ADA entitled plaintiffs—residents of Georgia Regional Hospital—to treatment in an integrated community setting as opposed to an “unnecessarily segregated”<sup>239</sup> state hospital.

Plaintiffs L.C. and E.W. challenged their placement at Georgia Regional Hospital, arguing that Title II of the ADA entitled them to “the most integrated setting appropriate to [their] needs.”<sup>240</sup> Although both plaintiffs were transferred to community settings prior to the court’s decision, the court declined to find the case moot as such cases were “capable of repetition, yet evading review.”<sup>241</sup> The district court had granted summary judgment to the plaintiffs, finding that the state’s failure to place them in an “appropriate community-based treatment program” violated the ADA,<sup>242</sup> and the state appealed. On appeal, the Eleventh Circuit affirmed the judgment that the state had discriminated against the plaintiffs, but also remanded for further findings related to the state’s defense that the relief sought by the plaintiffs would “fundamentally alter the nature of the service, program, or activity.”<sup>243</sup> On appeal, the Supreme Court, in a split opinion per Justice Ginsburg,<sup>244</sup> qualifiedly affirmed.<sup>245</sup> After setting out the provisions of the ADA that focused on the institutional segregation and isolation of persons with disabilities, and the discrimination faced by persons with disabilities (including “exclusion . . . [and] segregation”),<sup>246</sup> the Court reviewed key Department of Justice regulations, including the “integration regulation,”<sup>247</sup> pointing out that the case, as

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238. L.C. v. Olmstead, 138 F.3d 893 (11th Cir. 1998), *aff’d in part, vacated in part and remanded*, 527 U.S. 581, 587 (1999).

239. *Id.* at 897.

240. *Id.* at 895–96.

241. *Id.* at 895 n.2. (citing, *inter alia*, *Honig v. Doe*, 484 U.S. 305, 318–25 (1988)).

242. *Id.* at 895.

243. *Id.* (quoting 28 C.F.R. § 35.130(b)(7)).

244. Justices O’Connor, Breyer, and Souter joined Justice Ginsburg in most of her opinion. *Olmstead v. L.C.*, 527 U.S. 581, 587 (1999). Justice Stevens, who would have preferred to simply affirm the Eleventh Circuit’s opinion, joined with these four justices in all of the opinion save the portion that outlined the State’s obligations in such cases. *Id.* at 607–08 (Stevens, J., concurring in part and concurring in the judgment). Justice Kennedy filed a concurring opinion, joined in part by Justice Breyer. *Id.* at 608 (Kennedy, J., concurring in the judgment). Justice Thomas dissented for himself, the Chief Justice, and Justice Scalia. *Id.* at 615 (Thomas, J., dissenting).

245. *Id.* at 587.

246. *Id.* at 588–89 (quoting 42 U.S.C. §§ 121101(a)(2), (3), (5)).

247. *Id.* at 592 (quoting 28 C.F.R. § 35.130(d) (1998)).

presented, did *not* challenge their legitimacy.<sup>248</sup> The Court then set out its holding:

We affirm the Court of Appeals' decision in substantial part. Unjustified isolation, we hold, is properly regarded as discrimination based on disability. But we recognize, as well, the States' need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States' obligation to administer services with an even hand. Accordingly, we further hold that the Court of Appeals' remand instruction was unduly restrictive. In evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably.<sup>249</sup>

The Court endorsed the Department of Justice's position that "undue institutionalization qualifies as discrimination 'by reason of . . . disability,'"<sup>250</sup> and then characterized the ADA as having "stepped up earlier measures to secure opportunities for people with developmental disabilities to enjoy the benefits of community living,"<sup>251</sup> stressing how much more comprehensive the ADA was than had been "aspirational" or "hortatory" laws such as the Developmentally Disabled Assistance and Bill of Rights Act.<sup>252</sup> The Court then focused on what it saw as congressional judgment supporting the finding that "unjustified institutional isolation of persons with disabilities is a form of discrimination":

First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. *Cf. Allen v. Wright* ("There can be no doubt that [stigmatizing injury often caused by racial discrimination] is one of the most serious consequences of discriminatory government action."); *Los Angeles Dept. of Water and Power v. Manhart*, ("In forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of

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248. *Id.* at 592.

249. *Id.* at 597.

250. *Id.* at 597-98.

251. *Id.* at 599.

252. *Id.*; see also 2 PERLIN, MENTAL DISABILITY LAW (1st ed.), *supra* note 76, § 7.13.

men and women resulting from sex stereotypes.”) Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.<sup>253</sup>

The majority immediately clarified some qualifications in its opinion. It emphasized that the ADA did *not* “condone[] termination of institutional settings for persons unable to handle or benefit from community settings,”<sup>254</sup> that the states “generally may rely on the reasonable assessments of its own professionals in determining whether an individual” is eligible for community-based programs,<sup>255</sup> and that there was no requirement that “community-based treatment be imposed on patients who do not desire it.”<sup>256</sup> None of these issues, however, were present in the case before it: Georgia’s professionals determined that community-based treatment would be appropriate for the plaintiffs, both of whom desired such treatment.<sup>257</sup> The Court added one additional word of caution here:

We do not in this opinion hold that the ADA imposes on the States a “standard of care” for whatever medical services they render, or that the ADA requires States to “provide a certain level of benefits to individuals with disabilities.” We do hold, however, that States must adhere to the ADA’s nondiscrimination requirement with regard to the services they in fact provide.<sup>258</sup>

The Court then turned to the questions of remedy and enforcement.<sup>259</sup> It rejected the Eleventh Circuit’s construction of the “reasonable-modifications regulation” as “unacceptable” in that “it would leave the State virtually defenseless” if the

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253. *Olmstead*, 527 U.S. at 600–01 (citations omitted).

254. *Id.* at 601–02.

255. *Id.* at 602.

256. *Id.*

257. *Id.* at 602–03.

258. *Id.* at 603 n.14 (citations omitted).

259. Although this section of the opinion was co-signed by only four Justices (Ginsburg, Souter, Breyer, and O’Connor), a reading of it in tandem with Justice Kennedy’s concurrence, *id.* at 608–15 (Kennedy, J., concurring in the judgment), makes it likely that it will be treated by lower courts as having the weight of a majority opinion.

plaintiff demonstrates she is qualified for the program or placement she seeks.<sup>260</sup> Rather, it concluded:

Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.<sup>261</sup>

The ADA, it concluded, “is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk,” nor is the law’s mission “to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter.”<sup>262</sup> For other patients, “no placement outside the institution may ever be appropriate.”<sup>263</sup> Because of these factors, Justice Ginsburg concluded that the state must have more leeway than offered by the Eleventh Circuit’s remedy:

If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.<sup>264</sup>

She summarized in this way:

[U]nder Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.<sup>265</sup>

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260. *Id.* at 603.

261. *Id.* at 604.

262. *Id.* at 604–05. At one point, Georgia had proposed such a placement for one of the named plaintiffs, and then later retracted it. *Id.* at 593.

263. *Id.* at 605. On this point, the opinion cited, *inter alia*, Justice Blackmun’s concurrence in *Youngberg v. Romeo*, 457 U.S. 307, 327 (1982) (Blackmun, J., concurring): “For many mentally retarded people, the difference between the capacity to do things for themselves within an institution and total dependence on the institution for all of their needs is as much liberty as they ever will know.” *See also Olmstead*, 527 U.S. at 605.

264. *Olmstead*, 527 U.S. at 605–06.

265. *Id.* at 607.



Justice Stevens concurred, stating that he would have preferred simply affirming the Eleventh Circuit's opinion, but because there were not five votes for that disposition, he joined in all of Justice Ginsburg's opinion, except for the remedy-enforcement portion.<sup>266</sup> Justice Kennedy concurred, urging "caution and circumspection" in the enforcement of the *Olmstead* case.<sup>267</sup> After stressing that "persons with mental disabilities have been subject to historic mistreatment, indifference, and hostility,"<sup>268</sup> he traced what he saw as the history of de-institutionalization: that, while it "has permitted a substantial number of mentally disabled persons to receive needed treatment with greater freedom and dignity," it "has its dark side" as well.<sup>269</sup> Here he quoted extensively from the writings of E. Fuller Torrey:

"For a substantial minority . . . de-institutionalization has been a psychiatric *Titanic*. Their lives are virtually devoid of 'dignity' or 'integrity of body, mind, and spirit.' 'Self-determination' often means merely that the person has a choice of soup kitchens. The 'least restrictive setting' frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies."<sup>270</sup>

It would be a "tragic event," Justice Kennedy warned, if states read the ADA—as construed in *Olmstead*—in such a way as to create an incentive for states, "for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision,"<sup>271</sup> and he thus emphasized that "opinion[s] of a responsible treating physician" should "be given the greatest of deference."<sup>272</sup> He underscored what he saw as a "common phenomenon":

It is a common phenomenon that a patient functions well with medication, yet, because of the mental illness itself, lacks the discipline or capacity to follow the regime the medication requires. This is illustrative of the factors a responsible physician will consider in recommending the appropriate setting or facility for treatment.<sup>273</sup>

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266. *Id.* at 607–08 (Stevens, J., concurring in part and concurring in the judgment).

267. *Id.* at 610 (Kennedy, J., concurring in the judgment).

268. *Id.* at 608 (Kennedy, J., concurring in the judgment).

269. *Id.* at 609 (Kennedy, J., concurring in the judgment).

270. *Id.* (Kennedy, J., concurring in the judgment) (quoting E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 11 (1997)).

271. *Id.* at 610 (Kennedy, J., concurring in the judgment).

272. *Id.* (Kennedy, J., concurring in the judgment).

273. *Id.* (Kennedy, J., concurring in the judgment).

Because of these concerns—and his fear that “States may be pressured into attempting compliance on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition”—Justice Kennedy again urged “caution and circumspection” and “great deference to the medical decisions of the responsible, treating physicians.”<sup>274</sup>

He continued<sup>275</sup> by articulating what he saw as the necessary elements of a discrimination finding,<sup>276</sup> and then raised federalism concerns: “Grave constitutional concerns are raised when a federal court is given the authority to review the State’s choices in basic matters such as establishing or declining to establish new programs. It is not reasonable to read the ADA to permit court intervention in these decisions.”<sup>277</sup>

Finally, he parted company from Justice Ginsburg on the weight she gave to the congressional findings. The findings in question, he concluded, “do not show that segregation and institutionalization are always discriminatory or that segregation or institutionalization are, by their nature, forms of prohibited discrimination.”<sup>278</sup> Instead, he reasoned, “they underscore Congress’ concern that discrimination has been a frequent and pervasive problem in institutional settings and policies and its concern that segregating disabled persons from others can be discriminatory.”<sup>279</sup>

Justice Thomas dissented, criticizing the majority opinion for its interpreting “discrimination” as encompassing “disparate treatment among members of the *same* protected class,”<sup>280</sup> arguing that the congressional findings on which the majority premised its conclusions were “vague” and “written in general hortatory terms,”<sup>281</sup> that its approach imposed “significant

274. *Id.* (Kennedy, J., concurring in the judgment).

275. Justice Breyer joined in the prior portion of Justice Kennedy’s concurrence, but not in the portion discussed *infra* at text accompanying notes 276–79. *Olmstead*, 527 U.S. at 608 (Breyer, J., concurring in the judgment).

276. Justice Kennedy stated:

If they could show that persons needing psychiatric or other medical services to treat a mental disability are subject to a more onerous condition than are persons eligible for other existing state medical services, and if removal of the condition would not be a fundamental alteration of a program or require the creation of a new one, then the beginnings of a discrimination case would be established.

*Id.* at 612 (Kennedy, J., concurring in the judgment).

277. *Id.* at 612–13 (Kennedy, J., concurring in the judgment).

278. *Id.* at 614 (Kennedy, J., concurring in the judgment).

279. *Id.* (Kennedy, J., concurring in the judgment).

280. *Id.* at 615–16 (Thomas, J., dissenting).

281. *Id.* at 620–21 (Thomas, J., dissenting).

federalism costs,”<sup>282</sup> and warning that states “will now be forced to defend themselves in federal court every time resources prevent the immediate placement of a qualified individual.”<sup>283</sup> He concluded: “Continued institutional treatment of persons who, though now deemed treatable in a community placement, must wait their turn for placement does not establish that the denial of community placement occurred ‘by reason of’ their disability. Rather, it establishes no more than the fact that petitioners have limited resources.”<sup>284</sup>

*Olmstead* is significant for several reasons. First, it is the first time that the Supreme Court has ruled on the applicability of the ADA to community-based treatment programs.<sup>285</sup> Second, it breathes important life into the congressional findings on questions of institutional segregation, discrimination and exclusion.<sup>286</sup> Third, it specifically focuses on the way that “[u]njustified isolation . . . is properly regarded as discrimination based on disability.”<sup>287</sup> Fourth, it comprehends how, in its own words, the ADA had “stepped up” prior congressional efforts in this area.<sup>288</sup> Fifth, it underscores how institutional isolation “perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life,”<sup>289</sup> and how such isolation “severely diminishes the everyday life activities of [institutionalized] individuals.”<sup>290</sup> And, for the purposes of this Article, most important, it endorses a least restrictive alternative mode of analysis in a civil institutional case.<sup>291</sup>

On the other hand, the Court’s “qualifiers” are equally important. The Court sanctions reliance on state professionals in

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282. *Id.* at 624 (Thomas, J., dissenting).

283. *Id.* at 625 (Thomas, J., dissenting).

284. *Id.* at 626 (Thomas, J., dissenting).

285. *Id.* at 607 (concluding that the ADA requires states to provide community-based treatment for persons with disabilities when the “placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated”).

286. *Id.* at 600 (noting congressional findings that society has historically discriminated against persons with disabilities and has attempted to isolate and segregate them).

287. *Id.* at 597.

288. *Id.* at 599 (declaring that the ADA built upon previous legislation to enable persons with developmental disabilities to benefit from community living).

289. *Id.* at 600.

290. *Id.* at 601.

291. *Id.* at 602, 605–06 (declaring that a state may place persons with mental disabilities in a less restrictive setting if the state provides both substantive safeguards in the form of opinions from treatment professionals and procedural safeguards in the form of a waiting list to move people into community settings).

determining community-treatment eligibility, thus, implicitly, endorsing a perpetuation of *Youngberg v. Romeo's* "substantial professional judgment" standard,<sup>292</sup> notwithstanding the fact that the Court had stressed that there was no constitutional issue presented in the case.<sup>293</sup> It emphasizes that *Olmstead* cannot be read as an opinion designed to "phase out" institutions or to move patients to inappropriate community settings.<sup>294</sup> And its "reasonable modifications" formula—by which a state must be able "to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings"<sup>295</sup>—provides an early partial blueprint for the resolution of similar future litigation.

Justice Kennedy's concurrence may turn out to be of critical importance for several reasons. First, he focuses squarely on the specter of inappropriate de-institutionalization, relying on Fuller Torrey's powerful critique.<sup>296</sup> Second, he raises the concern that the fear of litigation may lead the state to prematurely and inappropriately release patients "with too little assistance and supervision."<sup>297</sup> Finally, he links institutional release with patients' subsequent failure to self-medicate in community settings,<sup>298</sup> an argument that resonates in the current debate over involuntary outpatient commitment laws that premise community treatment on medication compliance.<sup>299</sup> It can be

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292. *Id.* at 602.

293. *Id.* at 588.

294. *Id.* at 604–05.

295. *Id.* at 605–06.

296. *Id.* at 609 (Kennedy, J., concurring in the judgment). In my mind, Torrey's critique is a terribly flawed one. See Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 87, 89, 95–96 (1991) [hereinafter Perlin, *Competency*] (arguing that social structures exist to transition patients from an institutional setting into the community and to create treatment programs that may ultimately be more effective than institutionalized treatment settings); Michael L. Perlin et al., *Therapeutic Jurisprudence and the Civil Rights of Institutionalized Mentally Disabled Persons: Hopeless Oxymoron or Path to Redemption?* 1 PSYCHOL. PUB. POL'Y & L. 80, 118 (1995) [hereinafter Perlin et al., *Therapeutic Jurisprudence*] (rejecting Torrey's premise that patients' rights lawyers impede the advancement of mental disability law).

297. *Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring in the judgment). On the impact of "litigaphobia" (fear of litigation) on mental disability law jurisprudence, see, for example, Michael L. Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 LAW & PSYCHOL. REV. 29, 61–62 (1992) (noting that mental health professionals are faced with an increased threat of litigation stemming from *Tarasoff* liability).

298. *Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring in the judgment) (speculating that if states are "pressured" into discharging patients from institutional settings, it is possible that some of the discharged patients will fail to comply with the requirements of their medication).

299. See 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-7.3.

expected that these arguments of Justice Kennedy's will be as much a factor in the subsequent debate on community treatment questions as will Justice Ginsburg's majority opinion.

### C. *Olmstead and the LRA*

*Olmstead's* explicit endorsement of a "least restrictive setting" principle in institutionalization/de-institutionalization cases requires a reconceptualization of some of the basic elements of mental disability law. First, the scope of involuntary civil commitment and periodic review hearings must be expanded so as to consider—as an element of the commitment process—an inquiry into the restrictivity of commitment. At such hearings, evidence of the impact of institutional segregation and the availability of community alternatives must be admissible. With this, of course, will inevitably come an expanded role of counsel (and, in some cases, experts) in helping the court craft orders that meet the requirements of *Olmstead*. Perhaps additional witnesses will need to be made available to testify as to comparative restrictivity of community settings, to the availability of such settings, and, in some cases, to the methodology used by the state in maintaining a "waiting list."<sup>300</sup> Periodic review hearings, especially, will have to refocus on the suitability and availability of LRA placements.<sup>301</sup>

Second, the meaning of "restrictivity of confinement" will need to be recalibrated. Will community settings always be less restrictive than institutional settings? Among competing community settings, how will most/least restrictive be defined or determined?<sup>302</sup> To what extent will these be objective determinations (based on some standardized criteria of

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300. Refer to notes 318–22 *infra* and accompanying text (discussing the need to place persons with disabilities in the most appropriate setting, with procedural safeguards in effect to ensure that those placed in group settings will have a mechanism to be de-institutionalized).

301. On periodic review in general, see 1 PERLIN, *MENTAL DISABILITY LAW*, *supra* note 1, at § 2C-6.5c.

302. The same dilemma is present in assessing the comparative restrictivity of antipsychotic medications, seclusion and restraints. Professor George Dix, for example, assumes that forced medication is more intrusive than seclusion or restraint. George E. Dix, *Legal and Ethical Issues in the Treatment and Handling of Violent Behavior*, in *CLINICAL TREATMENT OF THE VIOLENT PERSON* 178, 191 (Loren H. Roth ed., 1987). Arizona state policies categorize emergency medication as less restrictive than seclusion. David B. Wexler, *Seclusion and Restraint: Lessons from Law, Psychiatry, and Psychology*, 5 *INT'L J.L. & PSYCHIATRY* 285, 288 (1982). Dr. Paul Soloff agrees. *Id.* (referring to Paul H. Soloff, *Physical Controls: The Use of Seclusion and Restraint in Modern Psychiatric Practice*, in *CLINICAL TREATMENT*, *supra*, at 123). New Hampshire guidelines rate seclusion as less restrictive than physical restraints, which are, in turn, less restrictive than drugs. Wexler, *supra*, at 288.

“restrictivity”) or subjective (primarily taking into account the patient’s perspective). Just as Professor Bruce Winick created a “continuum of ‘intrusiv[ity]’” in his analysis of the right to refuse treatment,<sup>303</sup> so must a “continuum of restrictivity” be created to guide decisionmaking here.

Third, Justice Kennedy—by adopting E. Fuller Torrey’s de-institutionalization critique in his *Olmstead* concurrence<sup>304</sup>—has issued a challenge to those who believe that Justice Ginsburg’s majority opinion sets out an appropriate course of behavior in de-institutionalization cases. It is essential that his opinion be challenged—both in the courts and in the analytical and empirical literature—lest Torrey’s florid and hyperbolic cant set the tone for the subsequent debate.<sup>305</sup>

Fourth, the extent to which the “substantial professional judgment” language of *Youngberg v. Romeo*<sup>306</sup> will be engrafted into the analysis of post-*Olmstead* de-institutionalization cases is far from clear. *Olmstead* counsels great deference to the decisions made by institutional professionals,<sup>307</sup> yet, tellingly, the *Youngberg* standard is never explicitly endorsed. If there is a lacuna between *Youngberg* and *Olmstead* on this question, careful exploration of this apparent gap in reasoning is essential.

Fifth, *Olmstead* should encourage patient advocates to resuscitate the path of litigation that died in the wake of the Supreme Court’s second *Pennhurst State School* decision to force states to create community alternatives. This is clearly beyond the scope of the *Olmstead* opinion; Justice Ginsburg specifies that there was no constitutional issue presented to the Court in that case.<sup>308</sup> Yet, I believe that the attention that must now be focused at the commitment/periodic review hearing on restrictivity of conditions will reinvigorate this debate and will,

303. BRUCE J. WINICK, *THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT* 23 (1997) (proposing a function that links a treatment method to its associated intrusiveness factor, whereby constitutional protection of the patient is triggered when the level of intrusiveness exceeds a given threshold).

304. Refer to text accompanying note 270 *supra*.

305. For my earlier critique of Torrey’s writings, see Perlin et al., *Therapeutic Jurisprudence*, *supra* note 296, at 118.

306. 457 U.S. 307, 323 (1982) (declaring that treatment decisions by professionals are presumed valid and that “liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment . . . as to demonstrate that the person responsible actually did not base the decision on such a judgment”).

307. See *Olmstead v. L.C.*, 527 U.S. 581, 602 (1999) (“The State generally may rely on the reasonable assessments of its own professionals in determining whether an individual ‘meets the essential eligibility requirements’ for habilitation in a community-based program.”).

308. *Id.* at 588.

ultimately, augur a return to the sort of creative litigational efforts not seen in this area for more than fifteen years.

Sixth, *Olmstead* requires us to rethink the trend towards outpatient commitment, as reflected in such legislation as New York's "Kendra's Law."<sup>309</sup> Outpatient commitment laws began as a means of expanding less restrictive options for inpatients; over the years, they have been transmuted into vehicles for the exertion of greater social control over individuals not in inpatient psychiatric hospitals.<sup>310</sup> *Olmstead* forces us to reexamine this change of direction, and may also—eventually—force us to confront the role of forced medication in the out-patient clinic enterprise.<sup>311</sup>

Finally, *Olmstead* will require that states—such as New Jersey—that currently employ categories such as "discharged pending placement" or "commitment extended pending placement"<sup>312</sup> to abandon (or, at least, radically restructure) these categories if they lead to lengthier (and more restrictive) periods of in-patient institutionalization for those who can, in Justice Ginsburg's phrase, "handle and benefit from community settings."<sup>313</sup> It is not unreasonable to expect the development of a new body of case law on this precise question.

*Olmstead* may affect implementation of the LRA in other, subtler ways. Some revolve around the use of antipsychotic drugs. Evidence suggests that such medications are used less frequently in group homes and other community living arrangements than in larger institutional settings.<sup>314</sup> Since

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309. N.Y. MENTAL HYG. LAW §§ 9.48, 9.60 (McKinney Supp. 2000) (providing standing for a class of people to seek a court order requiring the severely mentally ill to obtain assisted outpatient treatment).

310. See 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-7.3.

311. See *id.* § 2C-7.3, at 497-98 (quoting Susan Stefan, *Preventive Commitment: The Concept and its Pitfalls*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 288, 294 (1987) (declaring that medication is the "core of outpatient treatment"), Steven J. Schwartz & Cathy E. Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values*, 20 LOY. L.A. L. REV. 1329, 1368 (1987) (stating that outpatient commitment is "synonymous with forced medications").

312. See 1 PERLIN, MENTAL DISABILITY LAW, *supra* note 1, § 2C-6.3. Refer to text accompanying note 171 *supra*.

313. *Olmstead*, 527 U.S. at 600.

314. See, e.g., Scott Spreat & James Conroy, *Use of Psychotropic Medications for Persons with Mental Retardation Who Live in Oklahoma Nursing Homes*, 49 PSYCHIATRIC SERVICES 510, 512 (1998) (describing a study that found that mentally retarded individuals in group homes are given antipsychotic medication less frequently than those in nursing homes); Maura Lerner & Joe Rigert, *Minnesota Now Has Low Rate of Medicating the Mentally Retarded*, MINNEAPOLIS-ST. PAUL STAR TRIB. July 2, 1989, available at 1989 WL 3728068 (reporting that 16% of the patients with mental retardation in group homes were given tranquilizers as compared to 26% of those in larger institutions).

*Rennie v. Klein* abandoned the least restrictive alternative in a drug refusal case in the aftermath of *Youngberg v. Romeo*,<sup>315</sup> few cases have explored the relationship between the LRA and the right to refuse medication.<sup>316</sup> *Olmstead*'s invocation of "least restrictive settings" language may once again lead courts to consider the relationship between drugging policies and restrictivity of confinement.<sup>317</sup>

In the aftermath of *Olmstead*, patient advocates quickly focused on implementation issues. Steven Gold,<sup>318</sup> for example, has asked: "What state has any plan, let alone one that is either 'comprehensive' or 'effectively working' to move people out of nursing homes or other institutions? Remember, the state's plan must positively show how, who, when, etc. people will be moved out of institutions."<sup>319</sup>

Similarly, Timothy Westmoreland and Thomas Perez, officials with the U.S. Health Care Financing Administration, have urged in a letter to all state Medicaid directors, that states "[d]evelop a comprehensive, effectively working plan . . . to strengthen community service systems and serve people with disabilities in the most integrated setting appropriate to their needs."<sup>320</sup> They focused not only on the adequacy of implementation plans but, strikingly, on the involvement of persons with disabilities in the creation of these plans.<sup>321</sup> Added

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315. *Rennie v. Klein*, 720 F.2d 266, 269, 270 (3d Cir. 1983) (rejecting the "least intrusive means" concept in light of *Youngberg*).

316. *But see State v. Nording*, 485 N.W.2d 781, 787 (N.D. 1992) ("This new legislation is designed to safeguard a patient's right to be free of forced medication unless the prescribed medication is necessary to effectively treat the patient, unless the medication is the least restrictive form of intervention available for the patient's treatment, and unless the benefits of the medication outweigh its known risks to the patient.").

317. Beyond the scope of this article is a consideration of the use of the newer, atypical antipsychotic drugs such as clozapine in this context. *See, e.g., Douglas Mossman, M.D. & Douglas S. Lehrer, M.D., Conventional and Atypical Antipsychotics, Novel Agents, and the Evolving Standard of Care*, 51 PSYCHIATRIC SERVICES 1528 (forthcoming) (2000).

318. Gold is a prominent Pennsylvania disabilities rights attorney. *See, e.g., Adapt of Phila. v. Phila. Hous. Auth.*, No. Civ. A. 98-4609, 2000 WL 433976, at \*1, \*10-11 (E.D. Pa. Apr. 14, 2000) (requiring the state of Pennsylvania to make at least 5% of public housing units accessible to people with mobility impairments); *Helen L. v. DiDario*, 46 F.3d 325, 327 (3d Cir. 1995) (voiding a Pennsylvania law that required a patient to receive state-sponsored care in a nursing home rather than in his or her own home).

319. Steve Gold et al., *Summary of Supreme Court's Decision in Olmstead v. L.C. & E.W.: Some Preliminary Thoughts*, INCITEMENT (ADAPT, Austin, TX), Spring-Summer 1999, at 10-11.

320. Timothy M. Westmoreland & Thomas Perez, *SMD Letter—Guidance on Olmstead Decision and Fact Sheet—1/14/00*, <http://www.hcfa.gov/medicaid/smd1140a.html> (last visited Aug. 30, 2000).

321. *See id.* ("The Department [of Health and Human Services] believes that comprehensive, effectively working plans are best achieved with the active involvement of



Gold: "Reasonable pace should be determined by organizations of people with disabilities. One test of 'reasonableness' should be how long your Governor would want to stay, unnecessarily and unjustified, in an institution or nursing home."<sup>322</sup>

In short, *Olmstead* offers a redemptive promise to persons with disabilities, especially to persons who are institutionalized and who can "handle" community placements. The next question to which I will turn is this: Can *Olmstead* stem the tide of sanism and pretextuality that engulfs the mental disability law system?

#### IV. SANISM, PRETEXTUALITY AND THERAPEUTIC JURISPRUDENCE

Earlier, I alluded to the impact of *sanism* and *pretextuality* on developments in this area. What do I mean by these terms? Simply put, "sanism" is an irrational prejudice of the same quality and character of other irrational prejudices that cause, and are reflected in, prevailing social attitudes of racism, sexism, homophobia and ethnic bigotry.<sup>323</sup> It infects both our jurisprudence and our lawyering practices.<sup>324</sup> Sanism is largely invisible and largely socially acceptable. It is based predominantly upon stereotype, myth, superstition and de-individualization, and is sustained and perpetuated by our use of alleged "ordinary common sense" (OCS) and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.<sup>325</sup>

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individuals with disabilities and their representatives in design, development and implementation."); Gold et al., *supra* note 319 ("We believe that states must, using organizations of people with disabilities such as ADAPT, centers for independent living, self-advocacy organizations, and psychiatric survivor groups identify all people who wish to leave institutions. Not a single state is doing that today.").

322. Gold et al., *supra* note 319.

323. Perlin, *Half-Wracked Prejudice*, *supra* note 148, at 4. The classic treatment is found in GORDON W. ALLPORT, *THE NATURE OF PREJUDICE* 107-25, 372-77 (1954) (noting that the facts we have about group differences largely fail to account for our prejudices). For an important new, and different, perspective, see ELISABETH YOUNG-BRUEHL, *THE ANATOMY OF PREJUDICES* (1996). See generally PERLIN, *THE HIDDEN PREJUDICE*, *supra* note 201, at ch. 2 (discussing roots of sanism and the relationship between sanism and other "ismic" behavior, such as racism or sexism or homophobia).

324. The phrase "sanism" was, to the best of my knowledge, coined by Dr. Morton Birnbaum. See Morton Birnbaum, *The Right to Treatment: Some Comments on its Development*, in MEDICAL, MORAL AND LEGAL ISSUES IN HEALTH CARE 97, 106-07 (Frank Ayd, Jr. ed., 1974.) See also *Koe v. Califano*, 573 F.2d 761, 764 (2d Cir. 1978) (noting that it may be difficult to find attorneys who will represent "these unfortunate people," either because there is little hope of recouping a fee or because of a discriminatory attitude, perhaps unconscious, against the mentally ill); Perlin, *Competency*, *supra* note 296, at 92-93.

325. See generally MICHAEL L. PERLIN, *THE JURISPRUDENCE OF THE INSANITY DEFENSE* (1994).

"Pretextuality" means that courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (frequently meretricious) decisionmaking, specifically where witnesses, especially *expert* witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends."<sup>326</sup> This pretextuality is poisonous; it infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blase judging, and, at times, perjurious and/or corrupt testifying.

In a series of recent articles and a new book (*The Hidden Prejudice: Mental Disability on Trial*), I have sought to demonstrate that mental disability law is sanist and pretextual, no matter whether the topic in question is involuntary civil commitment law, institutional rights law, the right to sexual interaction, the insanity defense, competency to plead guilty or waive counsel, or the Federal Sentencing Guidelines.<sup>327</sup> The question can thus be posed in this manner: Does *Olmstead* stand alone as an outlier in defiance of this sorry record?

"Therapeutic jurisprudence" studies the role of the law as a therapeutic agent, recognizing that substantive rules, legal procedures and lawyers' roles may have either therapeutic or

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326. Charles M. Sevilla, *The Exclusionary Rule and Police Perjury*, 11 SAN DIEGO L. REV. 839, 840 (1974); Michael L. Perlin, *Morality and Pretextuality, Psychiatry and Law: Of "Ordinary Common Sense," Heuristic Reasoning, and Cognitive Dissonance*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 131, 133 (1991).

327. See generally PERLIN, *THE HIDDEN PREJUDICE*, *supra* note 201, at 200-04 (discussing sanism and the Americans with Disabilities Act); Perlin, *Half-Wracked Prejudice*, *supra* note 148, at 3-5, 28-36 (introducing several papers in a symposium, and concluding that mental disability law "is irrational and incoherent, and this irrationality and incoherence disables civil commitment law, institutional treatment law, civil rights law, and criminal procedure law"); Perlin et al., *Therapeutic Jurisprudence*, *supra* note 296, at 81-83 (discussing sanism and pretextuality); Michael L. Perlin & Deborah A. Dorfman, *Is It More Than "Dodging Lions and Wastin' Time"? Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases*, 2 PSYCHOL. PUB. POL'Y & L. 114, 116-17, 130 (1996) (discussing the adequacy of counsel and a person with mental disability's right to refuse treatment); Michael L. Perlin, *Decoding Right to Refuse Treatment Law*, 16 INT'L J.L. & PSYCHIATRY 151, 170-75 (1993) (discussing the legal regulation of mental health practice and "the right to refuse antipsychotic medication"); Michael L. Perlin, *Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?*, 20 N.Y.U. REV. L. & SOC. CHANGE 517, 519, 535-40 (1993-94) (discussing "the right of institutionalized persons with mental disabilities to engage in consensual sexual activity"); Michael L. Perlin, *"Dignity was the First to Leave": Godinez v. Moran, Colin Ferguson, and the Trial of Mentally Disabled Criminal Defendants*, 14 BEHAV. SCI. & L. 61, 64-65, 75-80 (1996) (discussing the arrest and trial of Colin Ferguson in the context of *Godinez v. Moran*, 362 U.S. 402 (1960), and the public attitude toward Ferguson's trial); Michael L. Perlin & Keri K. Gould, *Rashomon and the Criminal Law: Mental Disability and the Federal Sentencing Guidelines*, 22 AM. J. CRIM. L. 431, 435-36, 442-46 (1995) (discussing the application of the Federal Sentencing Guidelines to mentally disabled persons).

antitherapeutic consequences, and questioning whether such rules, procedures and roles can or should be reshaped so as to enhance their therapeutic potential, while not subordinating due process principles.<sup>328</sup> Recent therapeutic jurisprudence articles and essays have thus considered such matters as the insanity acquittee conditional release hearing, health care of mentally disabled prisoners, the psychotherapist-patient privilege, incompetency labeling, competency decision-making, juror decision-making in malpractice and negligent release litigation, competency to consent to treatment, competency to seek voluntary treatment, standards of psychotherapeutic tort liability, the effect of guilty pleas in sex offender cases, correctional law, health care delivery, "repressed memory" litigation, the impact of scientific discovery on substantive criminal law doctrine, and the competency to be executed.<sup>329</sup> I have weighed the therapeutic jurisprudence implications of much of mental disability law<sup>330</sup> and, again, in the final section of this paper, will consider those implications for the question I am here addressing.

#### V. SANISM, PRETEXTUALITY, THERAPEUTIC JURISPRUDENCE, *OLMSTEAD* AND THE LRA

I have written extensively about the sanist and pretextual bases of all mental disability law, including those aspects that are most relevant to this inquiry—involuntary civil commitment law, right to treatment law, and right to community treatment law.<sup>331</sup> I believe that the majority opinion in *Olmstead* is the

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328. See PERLIN, *THE HIDDEN PREJUDICE*, *supra* note 201, at 261–310; *id.* at 261 n.1 (citing, *inter alia*, DAVID B. WEXLER, *THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT* (1990); DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* (1991); DAVID B. WEXLER & BRUCE J. WINICK, *LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* (1996); BRUCE J. WINICK, *THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW* (1997); David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, 16 LAW & HUM. BEHAV. 27 (1992); David B. Wexler, *Applying the Law Therapeutically*, 5 APP'L. & PREVEN. PSYCHOL. 179 (1996); David B. Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, 1 PSYCHOL. PUB. POL'Y & L. 220 (1995); 1 PERLIN, *MENTAL DISABILITY LAW*, *supra* note 1, § 2D-3; *Bibliography of Therapeutic Jurisprudence*, 10 N.Y.L. SCH. J. HUM. RTS. 915 (1993)).

329. See, e.g., 1 PERLIN, *MENTAL DISABILITY LAW*, *supra* note 1, § 2D-3, at 535–40 nn.83–132 (citing articles).

330. See, e.g., PERLIN, *THE HIDDEN PREJUDICE*, *supra* note 201, at 273–303.

331. See *id.* at 79–125; Perlin, *Maggie's Farm*, *supra* note 29; Perlin, *Voluntary Delivery*, *supra* note 159; Perlin, *Sanist Attitudes*, *supra* note 201; Perlin, *Hidden Agendas*, *supra* note 236. See generally Michael L. Perlin, *Therapeutic Jurisprudence: Understanding the Sanist and Pretextual Bases of Mental Disability Law*, 20 NEW ENG. J. CRIM. & CIV. CONFINEMENT 369 (1994) [hereinafter Perlin, *Sanist and Pretextual Bases*].

Supreme Court's most important majority non-sanist decision in the nearly a quarter of a century since *O'Connor v. Donaldson*.<sup>332</sup> In two recent articles, I discussed in an exploratory manner *Olmstead*'s potential for combating sanism and pretextuality in mental disability law in general,<sup>333</sup> and in the forensic mental health process in particular.<sup>334</sup> Here I want to turn to those aspects of mental disability law that are most closely related to LRA inquiries.

First, *Olmstead* has the capacity to transform involuntary civil commitment and periodic review hearings from their current often-feeble state of perfunctory lip service into vigorous and authentic inquiries into restrictivity of confinement and the availability of community treatment. These hearings have traditionally been pretextual<sup>335</sup> and sanist,<sup>336</sup> and *Olmstead* offers the first glimmer of hope in years that such hearings—if they are transformed in appropriate cases into vehicles that genuinely and thoughtfully consider restrictivity of confinement and availability of community placements and treatment—will provide authentic due process. As I have argued elsewhere, the provision of such due process is mental disability law at its most therapeutic.<sup>337</sup>

This will not happen, of course, unless counsel takes the lead. The inadequacy of lawyering in the involuntary civil commitment process is well-known;<sup>338</sup> its perpetuation—to which courts, legislatures and bar associations have been willfully blind for years—has been sanist and pretextual. Unless there is a profound shift in the attitudes of counsel (and in the attitudes of judges who assign counsel), *Olmstead* is in danger of being little more than another “paper victory”<sup>339</sup> for persons with mental disabilities.

332. 422 U.S. 563, 575–76 (1975) (establishing a right to liberty for nondangerous persons with mental illness).

333. Perlin, *Maggie's Farm*, *supra* note 29.

334. Perlin, *Misdemeanor Outlaw*, *supra* note 96.

335. See, e.g., Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625, 636–39 (1993).

336. See, e.g., Perlin, *On "Sanism," supra* note 213, at 400–04 (noting that “[c]riminal trial process case law is riddled with sanist stereotypes and myths”).

337. See Perlin et al., *Therapeutic Jurisprudence*, *supra* note 296; PERLIN, *THE HIDDEN PREJUDICE*, *supra* note 201, at 112. On the relationship between “procedural justice” and the involuntary civil commitment process, see Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 442–44 (1992). See also Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37, 38–44 (1999).

338. See Perlin, *Voluntary Delivery*, *supra* note 159, at 151.

339. I use this phrase in an ADA context in Perlin, *Sanist Attitudes*, *supra* note 201,

Creation of the “discharged pending placement” status<sup>340</sup> flowed from what were therapeutic motivations—the desire to transform involuntary civil commitment hearings into *placement* hearings for persons no longer dangerous but with “nowhere to go.”<sup>341</sup> In the intervening years since the New Jersey Supreme Court created this category in *In re S.L.*,<sup>342</sup> it is clear that this status has been used in significantly anti-therapeutic ways.<sup>343</sup> *Olmstead* offers the potential of reversing this anti-therapeutic trend. Similarly, the use of outpatient commitment status has shifted from a means of allowing certain patients more freedom to a way of insuring more state control over those not institutionalized (supported by the threat of institutionalization).<sup>344</sup> *Olmstead*—if taken seriously—forces a reconsideration of this “widening the net,”<sup>345</sup> and, perhaps, offers an opportunity for outpatient commitment to, once again, be a therapeutic, and not an anti-therapeutic tool.

Justice Ginsburg’s language about isolation and segregation in *Olmstead* may also lead to a revival of interest in constitutionally-based right-to-community services litigation. In an earlier article, I severely criticized the Supreme Court’s *Pennhurst* decisions with these words:

The Court’s decisions are profoundly antitherapeutic. Their failure to find a generic constitutional right to community services curbed litigation seeking to establish such a right. The initial *Pennhurst* decision, for all practical purposes, eviscerated the DD Act as a potential litigational tool for institutionalized persons with mental disabilities; the reaffirmation of the no-general-right-to-community-services

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at 22–23 (relying on Michael S. Lottman, *Paper Victories and Hard Realities*, in PAPER VICTORIES AND HARD REALITIES: THE IMPLEMENTATION OF THE LEGAL AND CONSTITUTIONAL RIGHTS OF THE MENTALLY DISABLED 93 (Valerie Bradley & Gary Clarke eds., 1976)).

340. Refer to note 312 *supra* and accompanying text (discussing “discharged pending placement” classifications).

341. Perlin, *Discharged Pending Placement*, *supra* note 171.

342. 462 A.2d 1252, 1253 (N.J. 1983) (explaining that patients classified as “discharged pending placement” are technically discharged, but that they remain in mental hospitals until appropriate outside placements become available).

343. See, e.g., *In re Commitment of G.G.*, 640 A.2d 1156, 1158–59 (N.J. Super. Ct. App. Div. 1994); *In re Commitment of Raymond S.*, 623 A.2d 249, 250, 252 (N.J. Super. Ct. App. Div. 1993).

344. E.g., Michael L. Perlin, “Outpatient Commitment: Historical Perspectives, Political Slogans, and Civil Libertarian Dilemmas” (paper presented to 25th Congress, International Academy of Law and Mental Health, Siena, Italy, July 2000); Michael L. Perlin, “Outpatient Commitment: Political Panacea or Pandora’s Box?” (paper presented to NY State Office of Court Administration Legal Update Program, Saratoga Springs, NY, January 2000).

345. Perlin, *Sanist and Pretextual Bases*, *supra* note 331, at 375.

in *Youngberg* ended most advocacy efforts to have such a right established. The second *Pennhurst* opinion effectively put an end to de-institutionalization/aftercare litigation as a strategy of patients' rights advocates.<sup>346</sup>

Only *Olmstead* offers the possibility of litigational redemption.

*Olmstead* has the potential to be the Supreme Court's most therapeutic decision since *Jackson v. Indiana*'s recognition that the "nature and duration" of civil commitments were constitutionally bound to each other.<sup>347</sup> We have known—for decades—that community treatment "works" better, that there is less improper use of antipsychotic medication in community settings, that community patients are less stigmatized, and stand a better chance of authentic reintegration into all aspects of social, economic and personal life.<sup>348</sup>

On the other hand, Justice Kennedy's concurrence raises troubling questions from a therapeutic jurisprudence perspective—by the use of the de-institutionalization-as-psychiatric-Titanic metaphor,<sup>349</sup> by his demonstration of "litigaphobia,"<sup>350</sup> and by his linkage of institutional release with failure to self-medicate in community settings.<sup>351</sup> It is essential that other academics and behavioral scholars turn their attention to these allegations, if *Olmstead* is truly to have a therapeutic impact on the mental disability law system.

## VI. CONCLUSION

*Lessard v. Schmidt*'s integration of the LRA principles into an involuntary civil commitment challenge refocused mental disability law in the early 1970s.<sup>352</sup> *Youngberg v. Romeo*'s failure

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346. Perlin, *Voluntary Delivery*, *supra* note 159, at 165 (essay published in 1996).

347. 406 U.S. 715, 738 (1972).

348. See Jennifer Gutterman, Note, *Waging a War on Drugs: Administering a Lethal Dose to Kendra's Law*, 68 FORDHAM L. REV. 2401, 2407–08 (2000) (noting that forty-one states currently have outpatient commitment statutes); Judi Clements, *Funding Care in the Community*, THE GUARDIAN, Jan. 8, 1999, 1999 WL 5104980 (stating that research "shows a steady 3 per cent annual decline in the proportion of homicides committed by people with mental disorders and suggests that public fear has been fuelled by selective reporting in the media").

349. *Olmstead v. L.C.*, 527 U.S. 581, 608–10 (1999) (Kennedy, J., concurring in the judgment).

350. See *id.* at 610 (Kennedy, J., concurring in the judgment); Stanley Brodsky, *Fear of Litigation in Mental Health Professionals*, 15 CRIM. JUST. & BEHAV. 492, 497 (1988) (illustrating that the disproportionate reactions of mental health professionals to the threat of suit have reached phobic proportions).

351. See *Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring in the judgment).

352. Refer to Part II.D *supra*.

to employ these principles in an institutional rights case confused matters in the early 1990s.<sup>353</sup> *Riggins v. Nevada*'s re-discovery of the LRA principle in a right to refuse treatment/fair trial case renewed interest in this aspect of mental disability law in the early 1990s.<sup>354</sup> And *Olmstead v. L.C.*'s endorsement of the principle in a community treatment case promised new life for mental disability law in the early 2000s.

*Olmstead*'s incorporation of the LRA principles—in a decision laden with language about “unnecessary isolation,” “institutional segregation,” and “erroneous” perceptions of persons with disabilities—may promise a new era in mental disability law. For the first time, a majority of the Supreme Court acknowledged the corrosive and debilitating effects of improper institutionalization.<sup>355</sup> For the first time, a majority of the Supreme Court acknowledged that such institutionalization “severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”<sup>356</sup> And, for the first time, the Supreme Court analogizes the corrosive impact of stereotypical perceptions—the heart of sanist attitudes—in cases involving race and sex to a case involving persons with mental disabilities.<sup>357</sup>

As I have already argued, *Olmstead*'s potential impact extends far beyond the relatively narrow statutory question directly before the Supreme Court in that case. It forces us to reconsider the scope of involuntary civil commitment and periodic review hearings, the use of hybrid categories such as DPP/CEPP,<sup>358</sup> and the expanded reliance on OPC, and may well serve as a “shot in the arm” to mostly-moribund constitutionally-

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353. Refer to Part II.E *supra*.

354. Refer to Part II.F *supra*.

355. Cf. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 462 (1985) (Marshall, J., concurring in the judgment in part and dissenting in part) (individuals with mental disabilities have been subject to “[a] regime of state-mandated segregation and degradation . . . that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow”).

356. *Olmstead*, 527 U.S. at 601 (citing Brief for American Psychiatric Association et al. as *Amici Curiae*, 20–22).

357. *Id.* at 600–01 (citing *Allen v. Wright*, 468 U.S. 737, 755 (1984) (“There can be no doubt that [stigmatizing injury often caused by racial discrimination] is one of the most serious consequences of discriminatory government action.”); *Los Angeles Dep’t of Water & Power v. Manhart*, 435 U.S. 702, 707 n.13 (1978) (“In forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.”)) (alterations in original).

358. Refer to note 171 *supra*.

based community treatment litigation.<sup>359</sup> It also “ups the ante” for lawyers representing persons with mental disabilities subject to institutionalization and those who are eligible for release.<sup>360</sup> At the same time, as I have argued, the concerns raised in Justice Kennedy’s separate opinion, however, must be carefully dealt with. To be charitable, Justice Thomas’s concerns in dissent—that states “will now be forced to defend themselves in federal court every time resources prevent the immediate placement of a qualified individual”<sup>361</sup>—are just plain silly,<sup>362</sup> and require no response save an observation that such an opinion reflects the degree to which Justice Thomas is out of touch with counsel’s pathetic record in providing legal services to persons with mental disabilities.<sup>363</sup>

Since *Olmstead* was decided, there has been surprisingly little follow-up litigation. In the year since *Olmstead* was decided, there have been remarkably few cases relying upon it. Lower federal courts and state courts have cited *Olmstead* for the proposition that “the ADA in fact prohibits segregation of persons with disabilities and requires states to make reasonable efforts to place institutionalized individuals with disabilities into the community”<sup>364</sup> in the “most integrated setting to fit their needs,”<sup>365</sup>

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359. Refer to notes 285–95 *supra* and accompanying text (describing the significance of the *Olmstead* decision).

360. Refer to Part III.C *supra* (discussing *Olmstead* and the least restrictive alternative).

361. *Olmstead*, 527 U.S. at 625 (Thomas, J., dissenting).

362. I was grateful to learn—after the fact—that I was not the first to apply this adjective to an opinion written by Justice Thomas. See Girardeau A. Spann, *Color-Coded Standing*, 80 CORNELL L. REV. 1422, 1466 (1995) (discussing Justice Thomas’s opinion in *Northeastern Florida Chapter of the Associated General Contractors of America v. City of Jacksonville*, 508 U.S. 656 (1993): “Moreover, Justice Thomas’s proffered distinction of *Warth* seems more silly than serious.”). See also Susan R. Klein, *The Discriminatory Application of Substantive Due Process: A Tale of Two Vehicles*, 1997 U. ILL. L. REV. 453, 463 n.54 (1997) (“At least Chief Justice Rehnquist and Justices Scalia and Thomas have remained relatively consistent in adhering to historical practices in forfeiture cases, no matter how outdated and silly these practices have become.”).

363. See 1 PERLIN, *MENTAL DISABILITY LAW*, *supra* note 1, § 2B-2, at 192 (“The record of the legal profession in providing meaningful advocacy services to persons with mental disabilities has been grossly inadequate.”).

364. *Rolland v. Cellucci*, 191 F.R.D. 3, 9 (D. Mass. 2000).

365. *Kathleen S. v. Dep’t of Pub. Welfare*, No. CIV A 97-6610, 1999 WL 1257284, at \*5 (E.D. Pa. Dec. 23, 1999). The Supreme Court of Indiana recently observed:

Since the 1970s, Indiana law has strongly reflected policies to de-institutionalize people with disabilities and integrate them into the least restrictive environment. . . . National policy changes have led the way for some of Indiana’s enactments in that several federal acts either guarantee the civil rights of people with disabilities or condition state aid upon state compliance with desegregation and integrationist practices.

*Creasy v. Rusk*, 730 N.E.2d 659, 664–66 (Ind. 2000) (citing, *inter alia*, *Olmstead*) (footnote omitted).



and have quoted *Olmstead*'s language that the ADA provides "a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."<sup>366</sup> And one federal court has rejected a state's cost-based arguments as "premature."<sup>367</sup> But, there are, as of yet, no cases that seriously reconceptualize the LRA after *Olmstead* in ways suggested in this Article. On the other hand, it is reasonable to suggest more creative litigation in the coming years.<sup>368</sup>

In *Gates of Eden*, Bob Dylan shared a vision of the otherworldly. "[T]here are no trials inside the Gates of Eden."<sup>369</sup> Like so many of Dylan's key lines, this is ultimately ambiguous: Do his words refer to legal trials, the trials of living, or something else? Whichever interpretation (or interpretations) we prefer, Dylan's vision is an egalitarian one ("There are no kings inside the Gates of Eden"),<sup>370</sup> based on pure freedom ("Leaving men wholly, totally free/To do anything they wish to do but die").<sup>371</sup> Like *Gates*, the Americans with Disabilities Act—seen initially as a type of Emancipation Proclamation<sup>372</sup>—made "promises of paradise"<sup>373</sup> for persons with disabilities. By its focus on the ravages of institutional segregation, *Olmstead* may, in some very important ways, make that promise real.

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366. *Kirbens v. Wyoming State Bd. of Med.*, 992 P.2d 1056, 1061 (Wyo. 1999).

367. *Lewis v. New Mexico Dep't of Health*, 94 F. Supp. 2d 1217, 1239 (D.N.M. 2000) ("Given the Supreme Court's holding that unjustified isolation does constitute disability discrimination under the ADA and that the right to integrated placements is a limited one, the Court finds Defendants' argument that the integration mandate impermissibly requires state expenditures premature at best.").

368. Wrote John Parry soon after *Olmstead* was decided:

Fundamentally, it expands the possibilities for persons in state-run mental institutions. Until *Olmstead*, the Court was suspicious of any kind of constitutionally based right to services in the community or least restrictive setting. In the past, the foundation of de-institutionalization was the absence of dangerousness to self or others, not the appropriateness of treatment or essential services in non-institutional settings. . . . The ADA's integration of service mandate, however, presented a new opportunity for advocates to obtain appropriate community-based services from the states, but many states argued that Title II did not obligate them to provide such services. Now that obligation is beyond dispute.

John W. Parry, *The Supreme Court Interprets the ADA*, 23 MENTAL & PHYSICAL DISABILITY L. REP. 454, 456 (1999) (citations omitted).

369. DYLAN, *supra* note 33, at 175.

370. *Id.* at 174.

371. *Id.* at 175.

372. Refer to note 204 *supra*.

373. DYLAN, *supra* note 33, at 174.